



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

R.E.D. Mental Health Report

Investigating Racial and Ethnic Disparities for Youth in
Santa Barbara County's Behavioral Wellness System

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Table of Contents

1.	Introduction	Page 3
	a. The R.E.D. Grant	Page 3
	b. Background Information about Disparities in Mental Health Systems	Page 3
	c. Intersections between Juvenile Justice and Mental Health.....	Page 6
	d. The Current Evaluation	Page 8
2.	An Examination of Racial and Ethnic Disparities in Mental Health Services in Santa Barbara County	Page 9
	a. County and Client Demographics	Page 9
	b. Referrals.....	Page 12
	c. Diagnoses.....	Page 15
	d. Treatment.....	Page 21
	e. Outcomes	Page 35
	f. Summary of Findings	Page 41
3.	Implications.....	Page 44

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Introduction

The R.E.D. Grant

The Board of State and Community Corrections (BSCC) Federal Formula Grants program awarded Santa Barbara County a grant to combat racial and ethnic disproportionalities in the juvenile justice system. The purpose of the Reducing Racial and Ethnic Disparities (R.E.D.) grant is to decrease the overrepresentation of youth of color who are involved in the juvenile justice system. Specifically, the grant has two main goals: a) to reduce the number of youth of color that have contact with the juvenile justice system and b) to reduce bias in juvenile justice system policies and practices. Given that the juvenile justice system often intersects with other community systems, the grant requires that probation collaborate with other systems, namely education, child welfare, mental health, and law enforcement, to help identify and address racial and ethnic disproportionalities across systems to accomplish these goals.

Background Information about Disparities in Mental Health Systems

Systematic racial and ethnic disproportionalities have been demonstrated across a number of different systems, including criminal justice, education, child welfare, and mental health. Studies investigating racial and ethnic disproportionalities in the mental health system generally find that youth of color, namely Latino and African American children, are underrepresented in receipt of mental health treatment.^{1 2} These disproportionalities exist across a range of mental health problems, including suicidality,³ substance use

¹ Howell, E., & McFeeters, J. (2008). Children's mental health care: Differences by race/ethnicity in urban/rural areas. *Journal of Health Care for the Poor and Underserved*, 19(1), 237-247. doi: 10.1353/hpu.2008.0008

² Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9), 1548-1555.

³ Freedenthal, S. (2007). Racial disparities in mental health service use by adolescents who thought about or attempted suicide. *Suicide and Life-Threatening Behavior*, 37(1), 22-34.

disorders,⁴ and internalizing problems.⁵ These disproportionalities remain even after considering differences in sociodemographic factors.⁶

Youth of color are less likely to receive mental health services across a range of treatment modalities and these disproportionalities exist both in psychotherapy⁷ and psychotropic medication.^{8 9} Of particular concern is the underrepresentation of African American and Latino youth in early intervention services. One national longitudinal study conducted in 2011 reported that African American children eligible for early intervention services were 5 times less likely to receive them than White children.¹⁰ Similarly, Latino children with severe limitations due to autism receive fewer services compared to White children with similar levels of need.¹¹ Lack of early intervention services is highly concerning given that such services are critical for promoting positive development for children with autism and other developmental disorders.

Disparities in mental health treatment exist despite there being no evidence that children and adolescents of color have fewer mental health problems than their White peers. In fact, research indicates that the opposite may be true. Some researchers have found a higher prevalence of psychiatric disorders such as depression, anxiety disorders, substance abuse, and even eating disorders among racial and ethnic minorities.¹² Suicidal ideation and suicidal attempts may also be more common for Latino and African American youth compared to White youth.¹³ One possibility is that children of color are more likely to experience discrimination, which places them at risk for developing a variety of mental health problems, including depression, attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct disorder.^{14 15} Additionally, other theorists hypothesize that differences in levels of poverty and socioeconomic disadvantage may account for racial and ethnic discrepancies in mental health disorders as poverty is associated with higher risk of mental health problems. For example, one study examining the prevalence of mental health problems in children found that youth from low socioeconomic backgrounds were four times as likely to develop mental health problems as their peers.¹⁶ Other research confirms that **some** of the racial and ethnic

⁴ Cummings, J. R., Wen, H., & Druss, B. G. (2011). Racial/ethnic differences in treatment for substance use disorders among U.S. adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(12), 1265-1274

⁵ Gudino, O. G., Lau, A. S., Yeh, M., McCabe, K. M., & Hough, R. L. (2009). Understanding racial/ethnic disparities in youth mental health services: Do disparities vary by problem type? *Journal of Emotional and Behavioral Disorders, 17*(1), 3-16. doi: 10.1177/1063426608317710

⁶ Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*(2), 239-243.

⁷ Javier, J. R., Lahiff, M., Ferrer, R. R., & Huffman, L. C. (2010). Examining depressive symptoms and use of counseling in the past year among Filipino and non-Hispanic white adolescents in California. *Journal of Development and Behavioral Pediatrics, 31*, 295-303.

⁸ Hudson, J. L., Miller, G. E., & Kirby, J. B. (2007). Explaining racial and ethnic differences in children's use of stimulant medications. *Medical Care, 45*(11), 1068-1075.

⁹ Kirby, J. B., Hudson, J., & Miller, G. E. (2010). Explaining racial and ethnic differences in antidepressant use among adolescents. *Medical Care Research and Review, 67*(3), 342-363. doi: 10.1177/107755870935088

¹⁰ Feinberg, E., Silverstein, M., Donahue, S., & Bliss, R. (2011). The impact of race on participation in Part C Early Intervention services. *Journal of Developmental & Behavioral Pediatrics, 32*, 284-291.

¹¹ Magana, S., Parish, S. L., & Son, E. (2016). Functional severity and Latino ethnicity in specialty services for children with autism spectrum disorder. *Journal of Intellectual Disability Research, 60*(5), 424-434. doi: 10.1111/jir.12293

¹² Pumariega A. J., Rogers, K., Rothe, E. (2005) Culturally competent systems of care for children's mental health: Advances and challenges. *Community Mental Health Journal, 41*(5), 539-55.

¹³ Eaton, D.K., Kann, L., Kinchen, S., Shanklin, S., Ross, J., Hawkins, J., .. Wechsler, H. (2008). Youth risk behavior surveillance—United States, 2007. *MMWR Surveillance Summary, 57*(4), 1-131.

¹⁴ Colver, T. R., Elliott, M. N., Kanouse, D. E., Grunbaum, J. A., Schwebel, D. C., Gilliland, J., ... Schuster, M. A. (2009). Perceived racial/ethnic discrimination among fifth-grade students and its association with mental health. *American Journal of Public Health, 99*(5), 878-884. doi:10.2105/AJPH.2008.144329

¹⁵ Tobler, A. L., Maldonado-Molina, M. M., Staras, S. A. S., O'Mara, R. J., Livingston, M. D., & Komro, K. A. (2013). Perceived racial/ethnic discrimination, problem behaviors, and mental health among minority urban youth. *Ethnicity & Health, 18*(3), 337-349. doi: 10.1080/13557858.2012.730609

¹⁶ Adriaanse, M., Veling, W., Doreleijers, T., & van Domburgh, L. (2014). The link between ethnicity, social disadvantage and mental health problems in a school-based multiethnic sample of children in the Netherlands. *European Child and Adolescent Psychiatry, 23*, 1103-1113. doi: 10.1007/s00787-014-0564-5

disproportionalities in mental health diagnoses seem to be attributable to differences in socioeconomic status.¹⁷

Not all researchers find higher levels of psychiatric disorders among adolescents of color. A number of studies report similar levels of mental health problems for White youth and youth of color.^{18 19} One possible explanation for discrepancies in prevalence rates across different studies is that the likelihood of a diagnosis may vary for different racial and ethnic groups according to the specific diagnoses under consideration. For example, while African American children are more likely than White children to be diagnosed with disruptive behavior disorders (e.g., conduct disorder and oppositional defiant disorder) and psychotic disorders, they are less likely to be diagnosed with affective disorders and ADHD.^{20 21 22} Differences in prevalence rates for different types of mental health conditions may be indicative of problems with the way mental health conditions are diagnosed. Research documents that some diagnostic interviews used to diagnose adolescents with psychiatric disorders are biased against certain racial and ethnic groups.²³

Even when youth of color are accurately diagnosed, they are still less likely to be able to access mental health services compared to their peers. One of the most commonly cited reasons for limited access to mental health services for youth of color is the higher rate of poverty among this population.^{24 25} However, even after controlling for poverty, African American and Latino individuals with mental needs are less likely to receive treatment compared to White individuals.^{26 27} A number of other factors have been implicated in the disproportionality of mental health services for youth of color. These explanations include structural factors, including lack of insurance, lack of information about available services and when to seek care, and insufficient availability of mental services in communities of color, as well as cultural factors, such as beliefs about mental health, fear of stigma, and distrust of the system.^{28 29} Additionally, lack of language proficiency in English may be another barrier for some individuals. In addition to racial and ethnic disparities, there are also disparities in mental health treatment for individuals with limited English proficiency: non-English

¹⁷ Williams, D. R., & Earl, T. R. (2007). Commentary: Race and mental health – more questions than answers. *International Journal of Epidemiology*, 36, 758-760. doi:10.1093/ije/dym114

¹⁸ Roberts, R. E., & Roberts, C. R. (2007). Ethnicity and risk of psychiatric disorder among adolescents. *Research in Human Development*, 4(1-2), 89-117. doi: 10.1080/15427600701481012

¹⁹ Rosenthal, B. S., & Wilson, W. C. (2012). Race/ethnicity and mental health in the first decade of the 21st century. *Psychological Reports*, 110(2), 645-662.

²⁰ Nguyen, L., Huang, L., Arganza, G. F., & Liao, Q. (2007). The influence of race and ethnicity on psychiatric diagnoses and clinical characteristics of children and adolescents in children's services. *Cultural Diversity and Ethnic Minority Psychology*, 13(1), 18-25. doi: 10.1037/1099-9809.13.1.18

²¹ Adebimpe, V. R. (2004). A second opinion on the use of White norms in psychiatric diagnosis of Black patients. *Psychiatry Annals*, 34, 543-51.

²² Morgan, P. L., Hillemeier, M. M., Farkas, G., & Maczuga, S. (2014). Racial/ethnic disparities in ADHD diagnosis by kindergarten entry. *Journal of Child Psychology and Psychiatry*, 55(8), 905-913. doi:10.1111/jcpp.12204

²³ Green, J. G., Gruber, M. J., Kessler, R. C., Lin, J. Y., McLaughlin, K. A., Sampson, N. A., ... Algeria, M. (2012). Diagnostic validity across racial and ethnic groups in the assessment of adolescent DSM-IV disorders. *International Journal of Methods in Psychiatric Research*, 21(3), 311-320. doi: 10.1002/mpr.1371

²⁴ Alegria, M., Vallas, M., & Pumariega, A. J. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinic of North America*, 19, 759-774. doi: 10.1016/j.chc.2010.07.001

²⁵ Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, 32, 1291-1299. doi:10.1016/j.childyouth.2010.04.021

²⁶ Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., & Ortega, A. N. (2003). Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino Whites. *Psychiatric Services*, 53(12), 1547-1555. doi: 10.1176/appi.ps.53.12.1547

²⁷ Zahner, G., Daskalakis, C. (1997). Factors associated with mental health, general health, and school-based service use for child psychopathology. *American Journal of Public Health*, 87(9), 1440-1448

²⁸ Alegria, M., Vallas, M., & Pumariega, A. J. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinic of North America*, 19, 759-774. doi: 10.1016/j.chc.2010.07.001

²⁹ Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, 32, 1291-1299. doi:10.1016/j.childyouth.2010.04.021

speaking individuals have significantly lower odds of receiving needed mental health services when controlling for other factors.³⁰

Even when individuals of color access mental health care, there is some evidence that they may not be receiving adequate services. A recent study conducted in 2015 found that African American and Hispanic participants were less likely than White participants to report favorable perceptions of the mental health care they received, even after controlling for demographic and health status factors.³¹ These negative perceptions were generally attributed to perceptions of discrimination and lack of culturally appropriate interventions. Most mental health providers have not been adequately trained to work effectively with clients of color.³² In addition, a significant number of mental health service providers have biases that influence their work with clients of color.³³ Culturally adapted interventions and interventions conducted in clients' native languages have been found to be more effective than standard treatments in treating linguistically and culturally diverse populations.³⁴ Unfortunately, such services are not always widely available.

Previous research, then, indicates that addressing disproportionalities within the mental health system is likely to be a complex process involving numerous interventions targeting different aspects of the mental health system. However, these interventions could have a major impact on reducing racial and ethnic disproportionalities within the juvenile justice system given the large percentage of youth within the juvenile justice system with demonstrated mental health needs.

Intersections between Juvenile Justice and Mental Health

There is a significant amount of overlap between youth served by the mental health system and youth involved in the juvenile justice system. A recent review of the literature concluded that adolescents involved in the juvenile justice system are significantly more likely to have identified special education disabilities and mental health disorders relative to the general population.³⁵ Approximately 70% of males detained by the juvenile justice system have at least one psychiatric disorder,³⁶ and this number may be higher among youth placed in correctional institutions. For example, one study estimated the prevalence of psychiatric disorders among youth in correctional facilities in Texas is as high as 98%.³⁷ Conduct disorder, substance use disorder, oppositional defiant disorder, and ADHD appear to be the most common psychiatric disorders

³⁰ Sentell, T., Shumway, M., & Snowden, L. (2007). Access to mental health treatment by English language proficiency and race/ethnicity. *Journal of General Internal Medicine*, 22(Suppl 2), 289-293. doi: 10.1007/s11606-007-0345-7

³¹ Cai, A., & Robst, J. (2015, October 12). The relationship between race/ethnicity and the perceived experience of mental health care. *American Journal of Orthopsychiatry*. Advance online publication. doi:10.1037/ort0000119

³² Casas, J. M., Suzuki, L. A., Alexander, C. M., & Jackson, M. A. (Eds.). (2017). *Handbook of multicultural counseling (4th ed.)*. Thousand Oaks, CA: SAGE Publications.

³³ Casas, J. M., Suzuki, L. A., Alexander, C. M., & Jackson, M. A. (Eds.). (2017). *Handbook of multicultural counseling (4th ed.)*. Thousand Oaks, CA: SAGE Publications.

³⁴ Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531-548. doi: 10.1037/0033-3204.43.4.531

³⁵ Mallett, C. A. (2014). Youthful offending and delinquency: The comorbid impact of maltreatment, mental health problems, and learning disabilities. *Child and Adolescence Social Work Journal*, 31, 369-392. doi: 10.1007/s10560-013-0323-3

³⁶ Colins, O., Vermeiren, R., Vreugdenhil, C., van den Brink, W., Doreleijers, T., & Broekaert, E. (2010). Psychiatric disorders in detained male adolescents: A systematic literature review. *The Canadian Journal of Psychiatry*, 55(4), 255-263.

³⁷ Harzke, A. J., Baillargeon, G., Olvera, R. L., & Penn, J. V. (2012). Prevalence of psychiatric disorders in the Texas juvenile correctional system. *Journal of Correctional Health Care*, 18(2), 143-157. doi: 10.1177/1078345811436000

among juvenile offenders; however, high rates of anxiety disorder, major depressive disorder, psychotic disorders, and post-traumatic stress disorder (PTSD) have also been observed.^{38 39}

Despite these high prevalence rates, very few juvenile offenders with mental health needs receive treatment - one study reported that less than a quarter of youth in the juvenile justice system with a diagnosed mental disorder received treatment.⁴⁰ Controlling for mental health needs, youth of color are significantly less likely to receive mental service referrals and utilization among juvenile offenders.^{41 42} A recent qualitative study exploring reasons for low mental health treatment utilization among African American juvenile offenders post-detention revealed that mental health stigma, ineffective treatment, fear and shame from peers, and mistrust of mental health providers were important barriers to service use.⁴³

Of particular concern for the prevention of youth of color coming into contact with the juvenile justice system is the how youth with substance use disorders are treated. Any type of substance use among minors is illegal and could be cause for referral to the criminal justice system. However, there seems to be differences concerning which youth receiving substance use treatment have concurrent involvement in the juvenile justice system and which do not. Among youth in treatment for substance use disorders, youth of color are significantly more likely to also be involved with the juvenile justice system than White adolescents even after controlling for criminal behaviors, substance abuse, mental health problems, and social and environmental risk factors.⁴⁴

Given the prevalence of youth with mental within the juvenile justice system, racial and ethnic disparities in mental health are likely to influence disproportionalities in the juvenile justice system. As such, efforts to promote equity in the juvenile justice system should also address disparities within the mental health system.

The Current Report

The purpose of the current report is to better understand disproportionalities in the mental health system in Santa Barbara County and how these disparities may contribute to the overrepresentation of youth of color within the juvenile justice system. Historical mental health data from the Department of Behavioral Wellness were examined. Data were reported for all clients under the age of 18 who received mental health or alcohol and drug services through the Department of Behavior Wellness (formerly referred to as the

³⁸ Collins, O., Vermeiren, R., Vreugdenhil, C., van den Brink, W., Doreleijers, T., & Broekaert, E. (2010). Psychiatric disorders in detained male adolescents: A systematic literature review. *The Canadian Journal of Psychiatry, 55*(4), 255-263.

³⁹ Maschi, T., Hatcher, S. S., Schwalbe, C. S., & Rosato, N. S. (2008). Mapping the social service pathways of youth to and through juvenile justice system: A comprehensive review. *Children and Youth Services Review, 30*, 1376-1385. doi: 10.1016/j.childyouth.2008.04.006

⁴⁰ Shelton, D. (2005). Patterns of treatment services and costs for young offenders with mental disorders. *Journal of Child and Adolescent Psychiatric Nursing, 18*(3), 103-112.

⁴¹ Rawal, P., Romansky, J., Jenuwine, M., & Lyons, J. S. (2004). Racial differences in the mental health needs and service utilization of youth in the juvenile justice system. *The Journal of Behavioral Health Services & Research, 31*(3), 242-254.

⁴² Janku, A. D., & Yan, J. (2009). Exploring patterns of court-ordered mental health services for juvenile offenders: Is there evidence of systemic bias? *Criminal Justice and Behavior, 36*(4), 402-419. doi: 10.1177/0093854808330799

⁴³ Samuel, I. A. (2015). Utilization of mental health services among African-American male adolescents released from juvenile detention: Examining reasons for within-group disparities in help-seeking behaviors. *Child and Adolescent Social Work Journal, 32*, 33-43. doi: 10.1007/s10560-014-0357-1

⁴⁴ Godette, D. C., Mulatu, M. S., Leonard, K. J., Randolph, S., & Williams, N. (2011). Racial/ethnic disparities and determinants of criminal justice involvement among youth in substance abuse treatment programs. *Journal of Correctional Health Care, 17*(4), 294-308. doi: 10.1177/1078345811413084

Alcohol, Drug, and Mental Health Services (ADMHS) Department) and were discharged between July 2009 and June 2014. Analyses were conducted to examine racial and ethnic disparities in referrals, diagnoses, treatment, and outcomes among youth receiving services.

The Department of Behavioral Wellness has an agreement with the Department of California Health Care Services to administer the Mental Health Plan for Santa Barbara County. Under this plan, the Department of Behavioral Wellness provides mental health and alcohol and drug treatment for individuals in Santa Barbara County. The Department of Behavioral Wellness is mandated to provide or arrange for the provision of specialty mental health services for the following clients: Medi-Cal beneficiaries with mental health needs; individuals who meet Welfare and Institutions Code Section 5150 criteria, indicating that they are a danger to themselves, others, or are gravely disabled as a result of mental health disorders; and people with serious mental illnesses not covered by federal programs or individual/family insurance. The primary use of funds is intended to serve seriously emotionally disturbed children or adolescents; people who need brief treatment as a result of a natural disaster or severe local emergency; adults requiring acute psychiatric care due to symptoms of psychosis, suicidality, or violence; homeless persons in need of mental health care; adults or older adults with serious mental disorder; individuals arrested or convicted of crimes; and California veterans in need of mental health services and who meet the existing eligibility requirements. Services are geared towards children with severe conditions who must meet medical necessity to receive ongoing services. Because the Department of Behavioral Wellness is intended to primarily serve the Medi-Cal eligible population in this county, the White youth population will be underrepresented in the data.

It is important to note that data used in this report came from pre-existing data systems within the Department of Behavioral Wellness. Behavioral Wellness has been working to improve the accuracy and completeness of the data collected by the agency. Results should be interpreted with caution as inaccuracies or missingness in the historical data collected by the agency will impact the correctness of the current findings.

An Examination of Racial and Ethnic Disparities in Mental Health Services in Santa Barbara County

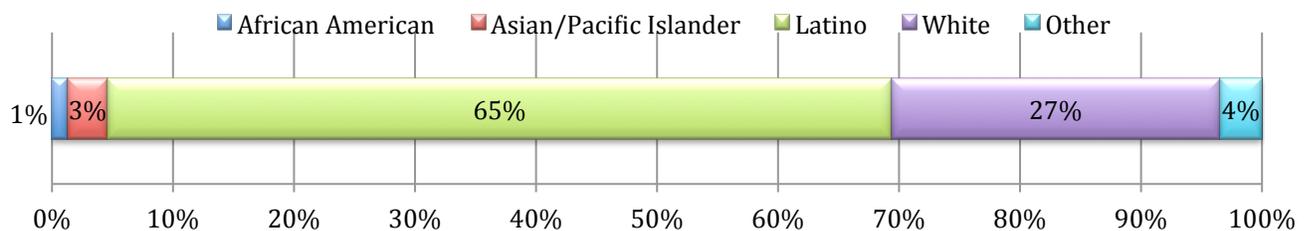
County and Client Demographics

County Demographics

The overall population in Santa Barbara County in 2015 was 435,639.⁴⁵ Of those, 98,532 (22.7%) individuals were under the age of 18.⁴⁶ Among the population of youth under the age of 18, the majority of individuals were either Latino/a (63,806; 64.8%) or White (26,703; 27.1%).⁴⁷ Other racial and ethnic groups represented included African American (1,250; 1.3%), Asian (3,203; 3.3%), Native American or Alaskan Native (311; 0.3%), Pacific Islander (98; <.1%), and multiracial (3,160; 3.2%).⁴⁸ Figure 1 presents the breakdown of the overall youth population in Santa Barbara County in 2015.

Given the small numbers of multiracial, Pacific Islander, and Native American/Alaska Native youth, racial/ethnic groups were collapsed into the following categories for the current report: White, African American, Latino/a, Asian or Pacific Islander, and Other (composed of Native American/Alaska Native and multiracial individuals).

Figure 1. Overall Youth Population in Santa Barbara County by Race/Ethnicity⁴⁹



Client Demographics

Between July 2009 and June 2014, there were 2,789 youth discharged after receiving mental health or alcohol and drug services through the Department of Behavioral Wellness in Santa Barbara County. Slightly more males ($n = 1,427$, 51.3%) than females ($n = 1,352$, 48.7%) received treatment. Figure 2 shows a breakdown of Behavioral Wellness's child and adolescent clients by race and ethnicity.

⁴⁵ California Department of Finance, Report P-3 Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Retrieved from <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>

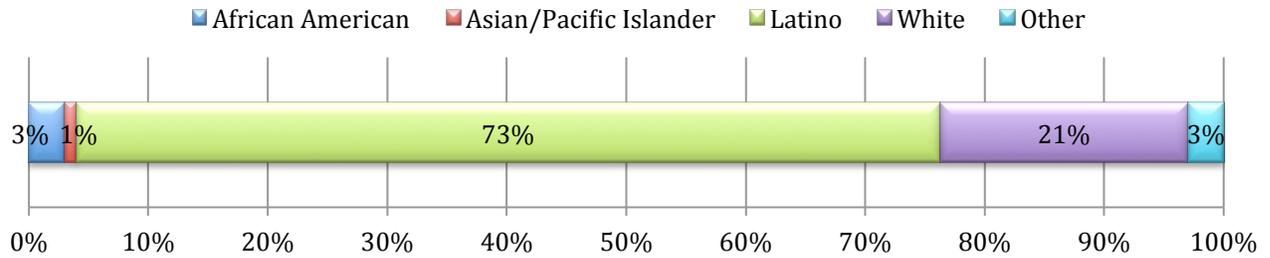
⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Ibid.

Figure 2. Santa Barbara County Department of Behavioral Wellness Client Population by Race and Ethnicity



Compared to White youth in the population, Asian/Pacific Islander youth were underrepresented in admissions to the Department of Behavioral Wellness. For every five White children admitted as clients, only one Asian/Pacific Islander child was admitted relative to their representation in the overall population. On the other hand, African American and Latino/a youth were overrepresented in Behavioral Wellness admissions. African American youth were admitted as clients at almost three times the rate of White youth. African American youth represented 1.3% of the overall youth population but 2.9% of admissions to the Department of Behavioral Wellness. Latino/a youth represented 61.7% of the overall youth population and 72.6% of the admissions to the Department of Behavioral Wellness. See Table 1 for a breakdown of disparities in admissions to Behavioral Wellness by race and ethnicity.⁵⁰

Table 1. Admissions to the Department of Behavioral Wellness by Race/Ethnicity

Santa Barbara (2015)	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Youth Population (age 0-17)⁵¹	26703	1250	63806	3301	3471	98531
<i>Population Percent</i>	<i>30.4%</i>	<i>1.3%</i>	<i>61.7%</i>	<i>3.1%</i>	<i>3.4%</i>	<i>100.0%</i>
Admissions	552	77	1914	15	79	2637⁵²
<i>Admissions Percent</i>	<i>20.9%</i>	<i>2.9%</i>	<i>72.6%</i>	<i>.6%</i>	<i>3.0%</i>	<i>100%</i>
Rate of Admission (per 1,000 youth in population)	20.7	61.6	30.0	4.54	22.8	26.8
Disparity Gap - Admissions	1.00	2.98	1.45	.22	1.10	1.29

	White	African American	Latino/a
Admissions	 1	 2.98	 1.45

⁵⁰ Given that there are racial and ethnic disproportionalities in the Medi-Cal eligible population in Santa Barbara County, White youth were expected to be underrepresented relative to many other racial and ethnic groups.

⁵¹ California Department of Finance, Report P-3 Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Retrieved from <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>

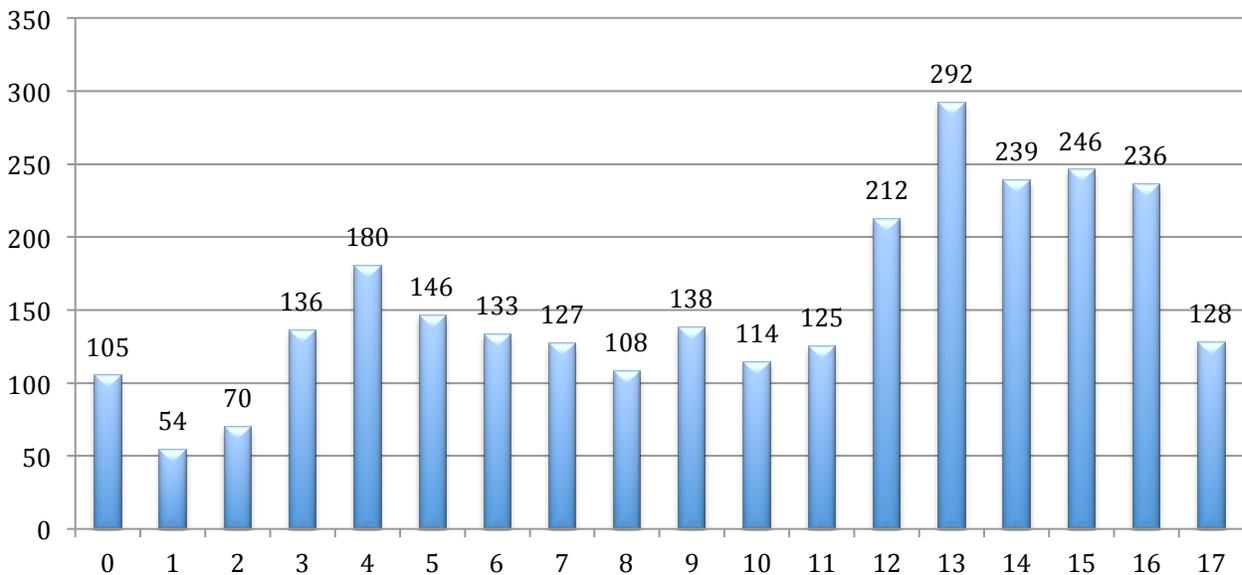
⁵² These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

Approximately 95% of clients were listed as having no insurance at some point while they were receiving services through the Department of Behavioral Wellness. Additionally, 89% of clients were listed as having Medicaid at some point while they were receiving services. Only 2% of clients had private insurance at any point while they were clients.

Information regarding the youths' primary language was available for 2,206 (79%) children and adolescents. Of these clients, 77% spoke English as their primary language, and 23% reported that Spanish was their primary language. Nine clients reported that their primary language was a language other than English or Spanish. Other languages spoken included American Sign Language, Mixtec, and Thai.

The average age of clients at first admission to the Department of Behavioral Wellness was approximately 9.9 years. Clients' ages at first admission ranged from less than 1 year to over 17 years. See Figure 3 for the distribution of clients' ages at first admission. There were no differences in average age at admission by race or ethnicity, but females were slightly older on average than males at first entry ($M = 10.2$, $M = 9.7$, respectively), and children who spoke a language other than English as their primary language were younger than children whose primary language was English ($M = 8.6$, $M = 9.7$, respectively).⁵³

Figure 3. Age of Clients at First Admission



Some of the youth served by the Department of Behavior Wellness were concurrently involved in the juvenile justice system. In total, 113 youth (4.1%) were on probation at some point while they were receiving mental health or alcohol and drug services. Males were more likely than females to be on probation (6% and 2%, respectively).⁵⁴

Latino/a, African American, and Other youth were disproportionately likely to be on probation compared to White youth. Whereas White youth comprised 20.9% of the clients of the Department of Behavioral Wellness, they only comprised 11.6% of the clients who were also on probation. Latino/a youth, on the other hand, comprised 72.6% of the clients of the Department of Behavioral Wellness and 82.1% of the clients also on probation. See Table 2 for a breakdown of concurrent juvenile justice and Department of Behavioral Wellness involvement by race and ethnicity.

⁵³ Using ANOVA, $p = .006$ and $p < .001$, respectively

⁵⁴ Using Chi Square, $p < .001$.

Table 2. Probation Involvement among Clients of the Department of Behavioral Wellness by Race/Ethnicity

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁵⁵
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Clients on Probation	13	3	92	0	4	112
<i>Probation Percent</i>	11.6%	2.7%	82.1%	0%	3.6%	100%
Rate on Probation (per 1,000 clients)	23.6	39.0	48.1	0	50.6	42.5
Disparity Gap - Probation	1.00	1.65	2.04	0	2.15	1.80

	White	African American	Latino/a
Behavioral Wellness Clients on Probation	 1	 1.65	 2.04

Referrals

Clients were referred for services from a variety of different sources, including treatment agencies, the criminal justice system, individual referrals (i.e., friends, family, and individuals), medical health care providers, crisis services, Child Welfare Services (CWS), community agencies, and schools. The largest number of youths were referred by schools or educational programs (n = 789) followed by individual referrals (n = 545) and treatment agencies (n = 499; see Table 3).

Table 3. Referral Sources for Behavioral Wellness Clients⁵⁶

Referral Source	Number of Clients
School (Schools and Educational Programs)	789
Individuals (Family and Friends, Home, Individuals (Including Self-Referrals))	545
Treatment Agency (Alcohol and Drug Programs; Treatment Courts; ADMHS, and Residential Care Programs)	499
Criminal Justice System (Probation, Law Enforcement, Jails and Prisons)	381
Child Welfare Services (CWS)	243
Community Agency	199
Medical Provider (Hospitals or Health Care Providers)	136

⁵⁵ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

⁵⁶ Some individuals may have been referred for services by more than one source.

Crisis Services (Mobile Crisis Services and Psychiatric Hold Orders)

79

After controlling for other background characteristics and diagnoses, only age and race or ethnicity predicted referral sources. Age was a significant predictor of all referral sources. Younger children were more likely to be referred by CWS⁵⁷; whereas the probability of having a referral from the criminal justice system or health care providers increased with age.⁵⁸

Table 4 presents referrals by agency type broken down by race and ethnicity. As can be seen in Table 4, compared to White youth, African American youths were overrepresented in referrals by treatment agencies, the criminal justice system, individuals, medical providers, CWS, and community agencies. In particular, compared to other racial and ethnic groups, African Americans were much more likely to be referred to treatment by CWS. While African American children and adolescents made up only 2.9% of the overall clients served by the Department of Behavioral Wellness, they comprised 7.4% of the population referred by CWS. African American youths were referred by CWS at twice the rate of White youths.

Compared to their White peers, Latino/a youths were overrepresented in referrals from schools. On the other hand, they were underrepresented in referrals from medical health care providers and CWS. Latino/a children and adolescents composed 72.6% of the Behavioral Wellness clients and only 60.7% of clients referred by CWS.

Compared to White youth, children and adolescents categorized as Other were overrepresented in referrals from treatment agencies, the criminal justice system, individuals, CWS and community agencies. On the other hand, they were underrepresented in referrals from schools. Only 3% of the clients served by Behavioral Wellness were classified as Other, yet they composed 5% of clients referred by CWS.

Table 4. Referral Sources among Clients of the Department of Behavioral Wellness by Race/ethnicity

	White	African American	Latino/a
CWS Referrals	 1	 2.02	 .66
Criminal Justice System Referrals	 1	 1.36	 .91

⁵⁷ Using logistic regression, $p = .042$.

⁵⁸ Using logistic regression, $p = .028$ and $p = .049$, respectively.

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁵⁹
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Treatment Agency Referrals	101	23	342	3	21	490
<i>Treatment Agency Referral Percent</i>	20.6%	4.7%	69.8%	.6%	4.3%	100%
Rate Referred by Treatment Agency (per 1,000 clients)	183.0	298.7	178.7	200.0	265.8	185.8
Disparity Gap – Treatment Agency	1.00	1.63	.98	1.09	1.45	1.02
Criminal Justice Referrals	79	15	248	3	15	360
<i>Criminal Justice Referral Percent</i>	21.9%	4.2%	68.9%	.8%	4.2%	100%
Rate Referred by Criminal Justice (per 1,000 clients)	143.1	194.8	129.6	200.0	189.9	136.5
Disparity Gap – Criminal Justice	1.00	1.36	.91	1.40	1.33	.95
Individual Referrals	103	20	360	4	21	508
<i>Individual Referral Percent</i>	20.3%	3.9%	70.9%	.8%	4.1%	100%
Rate Referred by Individuals (per 1,000 clients)	186.6	259.7	188.1	266.7	265.8	192.6
Disparity Gap - Individual	1.00	1.39	1.01	1.43	1.42	1.03
Medical Provider Referrals	31	6	85	1	4	127
<i>Medical Provider Referral Percent</i>	24.4%	4.7%	66.9%	.8%	3.1%	100%
Rate Referred by Medical Provider (per 1,000 clients)	56.2	77.9	44.4	66.7	50.6	48.2
Disparity Gap – Medical Provider	1.00	1.39	.79	1.19	.90	.86
Crisis Services Referrals	15	2	56	0	2	75
<i>Crisis Services Percent</i>	20.0%	2.7%	74.7%	0%	2.7%	100%
Rate Referred by Crisis Services (per 1,000 clients)	27.2	26.0	29.3	0	25.3	28.4
Disparity Gap – Crisis Services	1.00	.96	1.08	0	.93	1.05
CWS Referrals	64	18	147	1	12	242
<i>CWS Percent</i>	26.4%	7.4%	60.7%	.4%	5.0%	100%
Rate Referred by CWS (per 1,000 clients)	115.9	233.8	76.8	66.7	151.9	91.8
Disparity Gap - CWS	1.00	2.02	.66	.58	1.31	.79
Community Agency Referrals	37	7	137	2	8	191
<i>Community Agency Percent</i>	19.4%	3.7%	71.7%	1.0%	4.2%	100%
Rate Referred by Community Agencies (per 1,000 clients)	67.0	90.9	71.6	133.3	101.3	72.4
Disparity Gap – Community Agency	1.00	1.36	1.07	1.99	1.51	1.08
School Referrals	122	19	597	3	12	753
<i>School Percent</i>	16.2%	2.5%	79.3%	.4%	1.6%	100%
Rate Referred by Schools (per 1,000 clients)	221.0	246.8	311.9	200.0	151.9	285.6
Disparity Gap - School	1.00	1.12	1.41	.90	.69	1.29

⁵⁹ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

Diagnoses

Children and adolescents received services through the Department of Behavioral Wellness for a wide range of mental health problems, including Disorders of Infancy, Childhood, or Adolescence; Substance Use Disorders; Schizophrenia and other Psychotic Disorders; Mood Disorders; Anxiety Disorders; Factitious Disorders; Paraphilia or Sexual disorders; Eating Disorders; Insomnia; Impulse Control Disorders; Adjustment Disorders; Relational Problems; Child Abuse; and Phase of Life problems (see Table 5).⁶⁰ The most common problems reported were Adjustment Disorders ($n = 1180$), Substance Use Disorders ($n = 743$), Attention Deficit/Hyperactivity Disorder (ADHD) and other Disruptive Behavior Disorders ($n = 530$), Mood Disorders ($n = 525$), and Anxiety Disorders ($n = 345$). Many clients had more than one diagnosis. The number of diagnoses clients were given ranged from 0 to 8 with a mean of 1.45.

Table 5. Diagnoses of Behavioral Wellness Clients by Race or Ethnicity⁶¹

	Total	White	African American	Asian/Pacific Islander	Latino/a	Other
Adjustment Disorder	1180	222	39	8	838	37
Substance Use Disorder	743	126	22	5	572	11
Cannabis Abuse or Dependence	607	99	19	3	472	8
Alcohol Abuse or Dependence	155	28	4	0	120	2
Amphetamine Abuse or Dependence	38	4	1	0	32	1
Cocaine Abuse or Dependence	2	1	0	1	0	0
Hallucinogen Abuse or Dependence	2	0	0	0	2	0
Opioid Abuse or Dependence	2	2	0	0	0	0
Other Substance Abuse or Dependence	18	1	1	1	14	1
Mood Disorders	642	144	19	4	382	29
Depressive Disorders	525	102	14	4	331	24
<i>Major Depressive Disorders</i>	195	33	5	3	135	11
<i>Dysthymic Disorder</i>	360	7	4	1	49	5
<i>Other Depressive Disorder</i>	322	75	8	2	223	14
Bipolar Disorder	45	10	3	0	27	3
Mood Disorder due to Medical Condition	3	0	0	0	2	0
Other Mood Disorder	169	45	8	0	91	11
Disorders of Infancy, Childhood, or Adolescence	601	116	18	13	416	79
ADHD/Disruptive Behavior Disorder	530	97	17	2	368	27
<i>Disruptive Behavior Disorder</i>	249	35	6	0	184	11
<i>Oppositional Defiant Disorder</i>	119	22	4	1	83	6
<i>Conduct Disorder</i>	35	6	2	0	23	4
<i>ADHD</i>	181	46	6	1	114	11

⁶⁰ Classifications were based on the DSM-IV, as that was the edition of the DSM in use at the time of the study.

⁶¹ Some individuals had multiple disorders.

Autism Spectrum Disorder	36	8	0	0	26	0
Elimination Disorder	5	0	0	0	5	0
Communication Disorder	1	1	0	0	0	0
Other	60	19	3	0	36	2
<i>Reactive Attachment</i>	24	10	2	0	11	1
<i>Separation Anxiety</i>	21	7	1	0	12	1
<i>Selective Mutism</i>	3	0	0	0	3	0
<i>Other</i>	12	2	0	0	10	0
Anxiety Disorder	345	82	15	1	221	9
Post-Traumatic Stress Disorder (PTSD)	156	40	8	0	98	5
General Anxiety Disorder	48	13	1	0	32	1
Panic or Agoraphobia	8	3	0	0	3	2
Obsessive-Compulsive Disorder (OCD)	7	5	0	0	2	0
Social Phobia	6	2	1	0	3	0
Specific Phobia	2	0	0	0	2	0
Acute Stress Disorder	2	0	0	0	2	0
Other Anxiety Disorder	121	21	5	1	82	1
Schizophrenia/Psychotic Disorders	54	12	2	32	2	48
Schizophrenia	6	0	0	0	6	0
Schizoaffective Disorders	4	1	0	0	3	0
Other Psychotic Disorder	50	11	2	0	29	2
Impulse Control Disorder	18	4	1	0	12	1
Intermittent Explosive Disorder	10	2	1	0	6	1
Trichotillomania	1	0	0	0	1	0
Other Impulse Control	7	2	0	0	5	0
Relational Problems	5	0	0	0	4	1
Parent Child Relational Problems	4	0	0	0	3	1
Partner Relational Problems	1	0	0	0	1	0
Abuse	4	0	0	0	4	0
Physical Abuse of Child	3	0	0	0	3	0
Sexual Abuse of Child	1	0	0	0	1	0
Eating Disorder	2	0	0	0	2	0
Factitious Disorder	1	0	0	0	0	0
Paraphilia or Sexual Disorder	1	0	0	0	1	0
Insomnia	1	0	0	0	1	0
Phase of Life	1	0	0	0	1	0
No Disorder on Axis I	141	23	5	0	103	3

The prevalence rates of specific disorders differed for males and females across a number of disorders: males were more likely to have diagnoses for ADHD, Disruptive Behavior Disorders, Substance Use Disorders (except for Alcohol Disorders, which were more common among females), Autism, and Elimination Disorders.⁶² Females were more likely to have diagnoses for Mood Disorders and PTSD.⁶³

Children and adolescents who spoke a language other than English as their primary language were underrepresented in diagnoses for ADHD, Reactive Attachment Disorder, Cannabis Abuse or Dependence, Mood Disorders, and PTSD and were overrepresented in Disruptive Behavior Disorders and No Disorders on Axis I.⁶⁴

Youth in the Behavioral Wellness System who were on probation were more likely than their counterparts to have ADHD, Disruptive Behavior Disorders, Substance Used Disorders, and PTSD.⁶⁵ They were less likely to be classified as having an Adjustment Disorder or No Disorder on Axis I.⁶⁶

For the current evaluation, we focused specifically on the diagnostic groups that were frequent enough to be used in relevant statistical analyses. Those diagnoses and their descriptions are included in Table 6.

Table 6. Diagnostic Groups and Descriptions

DSM-IV Diagnostic Groups	DSM-IV Diagnostic Descriptions
ADHD	A persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development
Disruptive Behavior Disorders	Includes Conduct Disorder and Opposition Defiant Disorder; Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated OR a pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures
Substance Use Disorders	A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances
Psychotic Disorders	Characterized by the presence of psychotic symptoms, such as hallucinations and delusions, as the defining feature.
Mood Disorders	Includes Depressive Disorders and Bipolar Disorders; Characterized by a disturbance in mood (depression and/or mania) as the predominant feature.
Anxiety Disorders	A large category of disorders that includes anxiety as a predominant feature; includes Agoraphobia, Panic Disorder, Specific Phobias, Social Phobia, OCD, PTSD, and Generalized Anxiety Disorder
Adjustment Disorders	The essential feature of an Adjustment Disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors

Simple comparisons of types of diagnoses by racial and ethnic groups displayed a number of disproportionalities (see Table 7 for a complete breakdown of disparities in diagnoses by race and ethnicity). Compared to White youth, Latino/a youth were underrepresented in diagnoses for ADHD while students categorized as Other were overrepresented. Latino/a children and adolescents made up 72.6% of the overall

⁶² Using chi square, $p < .05$.

⁶³ Using chi square, $p < .05$.

⁶⁴ Using chi square, $p < .05$.

⁶⁵ Using chi square, $p < .05$.

⁶⁶ Using chi square, $p < .05$.

population served by Behavioral Wellness but only 64.0% of the diagnoses for ADHD; on the other hand, Other children and adolescents made up 3.0% of the overall population and 6.2% of ADHD diagnoses.

African American, Latino/a, and Other youth were more likely than White youth to have diagnoses for Disruptive Behavior Disorders, including Conduct Disorder and Oppositional Defiant Disorder. White children made up 20.9% of the overall population served by Behavioral Wellness but only 14.8% of children diagnosed with Disruptive Behavior Disorders.

Compared to White youth, Latino/a and Asian/Pacific Islander youth were more likely to have diagnoses for Substance Use Disorders whereas Other youth were underrepresented in this category. The opposite pattern emerged for Mood Disorders: Latino/a youth underrepresented and Other youth were overrepresented relative to their White peers. Latino/a children and adolescents also appeared to be somewhat underrepresented for psychotic disorders.

Table 7. Diagnoses for Department of Behavioral Wellness Clients by Race/Ethnicity

	White	African American	Latino/a
ADHD	 1	 .94	 .71
Disruptive Behavior Disorders	 1	 1.23	 1.52
Substance Use Disorders	 1	 1.25	 1.31

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁶⁷
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
ADHD	46	6	114	1	11	178
<i>ADHD Percent</i>	25.8%	3.4%	64.0%	.6%	6.2%	100%
Rate ADHD (per 1,000 clients)	83.3	77.9	59.6	66.7	139.2	67.5
Disparity Gap – ADHD	1.00	.94	.71	.80	1.67	.81
Disruptive Behavior Disorders	35	6	184	0	11	236
<i>Disruptive Behavior Percent</i>	14.8%	2.5%	78.0%	0%	4.7%	100%
Rate Disruptive Behavior (per 1,000 clients)	63.4	77.9	96.1	0	139.2	89.5
Disparity Gap – Disruptive Behavior	1.00	1.23	1.52	0	2.20	1.41
Substance Use Disorders	126	22	572	5	11	736
<i>Substance Use Percent</i>	17.1%	3.0%	77.7%	.7%	1.5%	100%
Rate Substance Use (per 1,000 clients)	228.3	285.7	298.9	333.3	139.2	279.1
Disparity Gap – Substance Use	1.00	1.25	1.31	1.46	.61	1.22
Psychotic Disorders	12	2	32	0	2	48
<i>Psychotic Disorders Percent</i>	25.0%	4.2%	66.7%	0%	4.2%	100%
Rate Psychotic Disorders (per 1,000 clients)	21.7	26.0	16.7	0	25.3	18.2
Disparity Gap – Psychotic Disorders	1.00	1.19	.77	0	1.16	.84
Mood Disorders	144	19	382	4	29	578
<i>Mood Disorders Percent</i>	24.9%	3.3%	66.1%	.7%	5.0%	100%
Rate Mood Disorders (per 1,000 clients)	260.9	246.8	199.6	266.7	367.1	219.2
Disparity Gap – Mood Disorders	1.00	.95	.77	1.02	1.41	.84
Anxiety Disorders	82	15	221	1	9	328
<i>Anxiety Disorders Percent</i>	25.0%	4.6%	67.4%	.3%	2.7%	100%
Rate Anxiety Disorders (per 1,000 clients)	148.6	194.8	115.5	66.7	113.9	124.4
Disparity Gap - Anxiety Disorders	1.00	1.31	.78	.45	.77	.84
Adjustment Disorders	222	39	838	8	37	1144
<i>Adjustment Disorders Percent</i>	19.4%	3.4%	73.3%	.7%	3.2%	100%
Rate Adjustment Disorders (per 1,000 clients)	402.2	506.4	437.8	533.3	468.4	433.8
Disparity Gap – Adjustment Disorders	1.00	1.26	1.09	1.33	1.16	1.08

Binary logistic regression analyses were used to determine what factors (i.e., gender, age, race and ethnicity, primary language, and probation status) predicted the likelihood of having different types of diagnoses after controlling for other factors (see Tables 8 and 9).

For ADHD, gender, age, Latino/a ethnicity, and having a primary language other than English were significant predictors after controlling for other demographic variables. Males and younger clients were more likely to

⁶⁷ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

have a diagnosis of ADHD. Latinos/as and youth who had a primary language other than English were less likely to have a diagnosis of ADHD.

Disruptive Behavior Disorders were predicted by gender and age. Younger children and males were more likely to have diagnoses of Disruptive Behavior Disorders than females or older youth.

A number of socio-demographic variables predicted the likelihood of having a Substance Use Disorder. Males and older youth were more likely to have Substance Use Disorders than females and younger children. African American and Latino/a youths were also overrepresented in Substance Use Disorders: the odds of being diagnosed with a Substance Use Disorder were 2.27 times greater for African American youth than White youth and 2.25 times greater for Latino/a youth than White youth. Children and adolescents with a primary language other than English, on the other hand, were less likely to have a Substance Use Disorder. Being on probation was the strongest predictor of Substance Use Disorders: the odds of having a diagnosis of Substance Use Disorder were 97 times higher for youth on probation than youth not on probation.

The only significant predictor of Schizophrenia and other Psychotic Disorders was age. Older youth were more likely than younger youth to have a diagnosis for a Psychotic Disorder.

Table 8. Socio-demographic Predictors of ADHD, Behavior Disorders, Substance Use Disorders, and Psychotic Disorders

	ADHD Odds Ratio (OR)	Disruptive Behavior Disorders Odds Ratio (OR)	Substance Use Disorders Odds Ratio (OR)	Psychotic Disorders Odds Ratio (OR)
Gender (female)	.28 (.19-.41)***	.48 (.36-.65)***	.53 (.40-.71)***	.43 (.18-1.00)
Age	.92 (.88-.95)***	.92 (.89-.95)***	1.46 (1.39-1.53)***	1.35 (1.23-1.47)***
African American	.74 (.30-1.84)	.99 (.40-2.47)	2.70 (1.30-5.58)**	1.23 (.16-9.51)
Asian/Pacific Islander	1.01 (.12-8.42)	-	.48 (.05-4.30)	.92 (.33-2.54)
Latino/a	.66 (.44-.98)*	1.23 (.82-1.85)	2.25 (1.56-3.24)***	1.46 (.14-15.69)
Other	1.45 (.69-3.05)	1.95 (.93-4.11)	.53 (.20-1.40)	-
Primary language (not English)	.53 (.33-.84)**	1.35 (.98-1.87)	.62 (.44-.89)**	.63 (.24-1.69)
Probation	1.67 (.81-3.43)	1.00 (.48-2.08)	97.74 (31.82-300.18)***	.32 (.03-4.00)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Slightly different patterns emerged for internalizing disorders, such as Mood Disorders and Anxiety Disorders. Females were more likely than males to have diagnoses for Mood Disorders and Anxiety Disorders. Additionally, older youth were more likely than younger youth to have a Mood Disorder. The odds of having a Mood Disorder were 1.8 times higher for youth classified as Other than White youth. Finally, children and adolescents with a Latino/a ethnicity were less likely to have Anxiety Disorders than their White peers.

Three socio-demographic variables predicted the likelihood of having an Adjustment Disorder: age, primary language, and probation status. Older adolescents, youth with a primary language other than English, and youth on probation were less likely to have diagnoses for Adjustment Disorders than their peers.

Table 9. Socio-demographic Predictors of Mood Disorders, Anxiety Disorders, and Adjustment Disorders

	Mood Disorders Odds Ratio (OR)	Anxiety Disorders Odds Ratio (OR)	Adjustment Disorders Odds Ratio (OR)
Gender (female)	2.32 (1.86-2.90)***	1.61 (1.26-2.07)***	1.17 (.98-1.40)
Age	1.23 (1.20-1.27)***	1.01 (.98-1.04)	.92 (.90-.94)***
African American	.89 (.48-1.62)	1.18 (.63-2.19)	1.42 (.86-2.36)
Asian/Pacific Islander	1.46 (.36-5.88)	.52 (.07-4.22)	2.10 (.57-7.71)
Latino/a	.87 (.66-1.13)	.73 (.54-.98)*	1.23 (.98-1.55)
Other	1.80 (1.01-3.21)*	.65 (.31-1.37)	1.25 (.75-2.08)
Primary language (not English)	.86 (.65-1.14)	1.05 (.77-1.43)	.76 (.61-.95)*
Probation	.70 (.44-1.11)	1.19 (.67-2.09)	.41 (.25-.67)***

* $p < .05$. ** $p < .01$. *** $p < .001$.

After controlling for background characteristics (gender, age, race and ethnicity, and primary language), the type of diagnosis a child had was a significant predictor of the referral source. Other treatment agencies were more likely to refer children and adolescents with ADHD, Disruptive Behavior Disorders, Psychotic Disorders, Anxiety Disorders, and Adjustment Disorders.⁶⁸ The criminal justice system was most likely to refer individuals with Disruptive Behavior Disorders, Substance Use Disorders, and Mood Disorders.⁶⁹ Individuals, (i.e., families and friends, and self) were more likely to refer children and adolescents with Disruptive Behavior Disorders, Psychotic Disorders, and Mood Disorders. Health care providers were more likely to refer individuals with Psychotic Disorders.⁷⁰ Crisis services were more likely to refer individuals with Mood Disorders.⁷¹ CWS was more likely to refer children and adolescents with Adjustment Disorders and Mood Disorders.⁷² Community organizations were more likely to refer individuals with Adjustment Disorders.⁷³ Finally, schools were more likely to refer children with Disruptive Behavior Disorders, Mood Disorders, and Anxiety Disorders.⁷⁴

Treatment

Of the 2,637 children and adolescents who received services from the Department of Behavioral Wellness, 61% attended treatment in South County, 29% attended treatment in North County, 18% attended treatment in West County, and 27% attended treatment Out of County. (Some youth received treatment in multiple locations, so the numbers do not add up to 100%). A breakdown of clients by race and ethnicity for each treatment region is presented in Figure 4.

⁶⁸ Using logistic regression, $p = .001$, $p = .003$, $p < .001$, $p < .001$, and $p = .011$, respectively.

⁶⁹ Using logistic regression, $p = .011$, $p = .013$, and $p = .019$, respectively.

⁷⁰ Using logistic regression, $p = .017$.

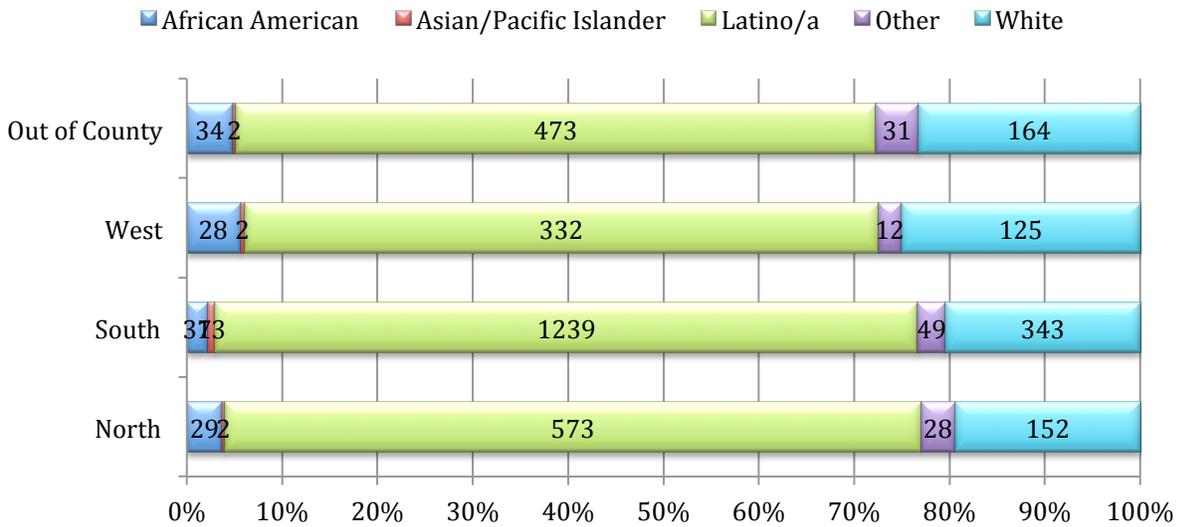
⁷¹ Using logistic regression, $p = .017$.

⁷² Using logistic regression, $p < .001$ and $p = .028$, respectively.

⁷³ Using logistic regression, $p = .005$.

⁷⁴ Using logistic regression, $p = .018$, $p = .001$, and $p = .017$, respectively.

Figure 4. Racial and Ethnic Breakdown of Clients by Treatment Area



The Department of Behavioral Wellness has three main types of treatment services: the Alcohol and Drug Program (ADP), the Managed Care Organization (MCO), and the Mental Health System (MHS). Table 10 presents racial and ethnic disparities in the type of treatment services in which clients were enrolled. As can be seen in Table 10, Latino/a and African American clients were disproportionately likely to be enrolled in ADP programs compared to White clients. Latino/a youth made up 72.6% of the overall client population, and they composed 78.1% of the ADP population. On the other hand, youth in the Other category were underrepresented in ADP. In MCO program enrollment, Latino/a, Asian or Pacific Islander, and Other children and adolescents were all underrepresented compared both to their representation in the overall client population and to White youth (who were overrepresented in MCO enrollment).

For the most part, the racial and ethnic composition of children and adolescents served by MHS was similar to the overall composition of Behavioral Wellness clients.

Table 10. Racial and Ethnic Disparities in Type of Program Enrollment

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁷⁵
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Alcohol and Drug Program (ADP)	127	22	584	4	11	748
<i>ADP Percent</i>	17.0%	2.9%	78.1%	.5%	1.5%	100%
Rate ADP (per 1,000 clients)	230.1	285.7	305.1	266.7	139.2	283.7
Disparity Gap - ADP	1.00	1.24	1.33	1.16	.61	1.23
Managed Care Organization (MCO)	132	19	283	3	12	449
<i>MCO Percent</i>	29.4%	4.2%	63.0%	.7%	2.7%	100%
Rate MCO (per 1,000 clients)	239.1	246.8	147.9	200.0	151.9	170.3
Disparity Gap - MCO	1.00	1.03	.62	.84	.64	.71
Mental Health Services (MHS)	414	64	1430	11	73	1992
<i>MHS Percent</i>	20.8%	3.2%	71.8%	.6%	3.7%	100%
Rate MHS (per 1,000 clients)	750.0	831.2	747.1	733.3	924.1	755.4
Disparity Gap - MHS	1.00	1.11	1.00	.98	1.23	1.01

To better untangle the effects of different socio-demographic variables on type of program enrollment, binary logistic regressions were conducted. Overall, results suggested that females were underrepresented in MCO enrollment. Youth with Anxiety Disorders were more likely to be served by MCO and less likely to be served by MHS than other youth. No racial and ethnic disproportionalities emerged when controlling for other background characteristics. See Table 11 for full results of regression analyses.

Table 11. Predictors of Receipt of MCO and MHS Services

	MCO Odds Ratio (OR)	MHS Odds Ratio (OR)
Gender (female)	.36 (.14-.95)*	1.37 (.20-9.15)
Age	1.11 (1.00-1.24)	.81 (.65-1.00)
African American	-	-
Asian/Pacific Islander	.65 (.23-1.88)	8.21 (.92-73.13)
Latino/a	.36 (.02-6.85)	-
Primary language (not English)	.49 (.17-1.42)	1.60 (.18-14.14)
Probation	3.89 (.14-108.40)	-
ADHD	1.06 (.25-4.55)	-
Disruptive Behavior Disorder	4.85 (.99-23.78)	.21 (.01-4.66)
Substance Use Disorder	.10 (.01-1.04)	-
Psychosis	1.85 (.57-5.96)	-
Mood Disorder	2.64 (.86-8.14)	-
Anxiety Disorder	6.72 (2.27-19.94)**	.06 (.01-.70)*
Adjustment Disorder	1.47 (.53-4.07)	-

* $p < .05$. ** $p < .01$. *** $p < .001$.

⁷⁵ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

Regression analyses could not be conducted for ADP enrollment. However, chi square statistics indicated that males and youth who spoke English as their primary language were more likely than females and youth who did not speak English as their native language to be served by ADP. Additionally, youth on probation was much more likely to be served by ADP: 24% of youth not on probation received services from ADP, and 96% of youth on probation received serves by ADP. Given that youth on probation were much more likely to have diagnoses for Substance Use Disorders, it makes sense that these youth are also overrepresented among ADP clients. Youth with diagnoses for Substance Use Disorders and Schizophrenia or other Psychotic Disorders were also more likely to be served by ADP.⁷⁶

Within each program type (i.e., MHS, ADP, and MCO), youth can be served across a number of different types of agencies. Some clients are served through county programs, others are served by agencies with contracts with Behavioral Wellness, and some clients are served by out-of-county programs or out-of-state residential programs. Of the sample of clients who were exited between July 2009 and June 2014, only one child was served in an out-of-state residential facility. Table 12 provides a breakdown of racial and ethnic representation in programs run by county agencies, contract agencies, and out-of-county agencies.

African American and Other youth were overrepresented among youth being served by county programs. While African American youth composed 2.9% of the overall population of Behavioral Wellness clients, they composed 4.0% of youth served in county programs. On the other hand, Latino/a youth were underrepresented in county programs.

Asian or Pacific Islander and Other youth were overrepresented in out-of-county facilities. For every one White youth served in out-of-county facilities, almost four Asian or Pacific Islander youth were served in out-of-county facilities.

Table 12. Racial and Ethnic Disparities in Agency Type

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁷⁷
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
County Agency	185	32	533	6	37	793
<i>County Agency Percent</i>	23.3%	4.0%	67.2%	.8%	4.7%	100%
Rate County Agency (per 1,000 clients)	335.1	415.6	278.5	400.0	468.4	300.7
Disparity Gap – County Agency	1.00	1.24	.83	1.19	1.40	.90
Contract Agency	452	71	1716	12	72	2323
<i>Contract Agency Percent</i>	19.5%	3.1%	73.9%	.5%	3.1%	100%
Rate Contract Agency (per 1,000 clients)	818.8	922.1	896.6	800.0	911.4	880.9
Disparity Gap – Contract Agency	1.00	1.13	1.09	.98	1.11	1.08
Out of County Facility	19	3	74	2	4	102
<i>Out of County Facility Percent</i>	18.6%	2.9%	72.5%	2.0%	3.9%	100%
Rate Out of County Facility (per 1,000 clients)	34.4	39.0	38.7	133.3	50.6	38.7
Disparity Gap – Out of County Facility	1.00	1.13	1.12	3.87	1.47	1.12

⁷⁶ All Chi Square statistics significant at $p < .05$.

⁷⁷ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

When examined concurrently with other types of socio-demographic predictors, race and ethnicity were no longer predictive of the type of agencies where youth were served. Age was a significant predictor, with younger students being more likely to be served by county agencies and older youths being more likely to be served by contract agencies. In addition, primary language was also predictive of agency type: the odds of having a being served by county agencies were 8 times higher for youth whose primary language was not English. Finally, diagnoses also predicted the type of agency where children and adolescents received services. The odds of being served by a county agency were greater for youth with a diagnosis of Adjustment Disorder. The odds of being served by a contract agency were greater for youth with diagnoses of ADHD, Disruptive Behavior Disorders, Substance Use Disorders, Psychosis, Mood Disorders, Anxiety Disorders, and Adjustment Disorders. Finally, the odds of being served by an out-of-county agency were greater for youths with Psychosis or Mood Disorders. The odds of being served by an out-of-county agency were over 96 times greater for youths with Psychotic Disorders and over 39 times greater for youths with Mood Disorders than for youths without those diagnoses.

Table 13. Predictors of Agency Type

	County Agency Odds Ratio (OR)	Contract Agency Odds Ratio (OR)	Out of County Agency Odds Ratio (OR)
Gender (female)	1.15 (.29-4.62)	.90 (.35-2.33)	.35 (.05-2.43)
Age	.75 (.63-.90)**	1.14 (1.02-1.28)*	1.09 (.84-1.41)
African American	2.00 (.15-27.41)	5.87 (.49-70.79)	-
Asian/Pacific Islander	3.41 (.76-15.33)	1.85 (.57-5.99)	.33 (.04-2.98)
Latino/a	-	6.28 (.08-512.24)	4.04 (.09-182.13)
Primary language (not English)	8.40 (1.12-63.06)*	1.02 (.35-2.95)	6.16 (.71-53.79)
ADHD	-	27.41 (2.85-263.87)**	1.14 (.07-18.83)
Disruptive Behavior Disorder	.55 (.04-7.14)	5.37 (1.03-28.11)*	8.23 (.25-272.59)
Substance Use Disorder	-	1.10 (.21-5.71)	.14 (.01-2.88)
Psychosis	7.38 (.84-64.80)	13.98 (3.38-58.87)***	96.58 (5.53-1686.21)**
Mood Disorder	7.90 (.72-86.42)	3.18 (.88-11.42)	39.33(4.09-378.48)**
Anxiety Disorder	.18 (.04-.83)	8.58 (2.61-28.27)***	1.09 (.14-8.55)
Adjustment Disorder	22.39 (1.88-266.37)*	3.95 (1.33-11.71)*	1.16 (.15-8.94)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Children and adolescents served by the Department of Behavioral Wellness participated in a number of different types of services. Table 14 shows a complete list of the programs that served youths in Santa Barbara County. These programs can be classified into the following categories: crisis services, residential services, substance use services, early intervention services, school-based services, in-home services, wraparound services, behavioral interventions, outpatient services, FFS (fee-for-services), intake and assessment services, and the parent partner program. Descriptions of each of the specific programs that served Behavioral Wellness clients are provided in Table 14 along with the number of youths who participated in each program. The largest numbers of youth was served by outpatient services ($n = 1667$) followed by crisis services ($n = 961$), substance use programs ($n = 762$), and in-home services ($n = 481$).

Table 14. Mental Health Programs that Served Youth in Santa Barbara County

Program	Description	Number of Participants
Crisis Services	Provide services for children and families experiencing mental health emergencies	961
<i>Crisis Triage</i>	<i>Assist individuals in gaining access to outpatient and crisis services in the least restrictive manner possible, including individuals in a pre-crisis state and those being discharged from inpatient care</i>	11
<i>Mobile Crisis Center</i>	<i>Mobile Crisis programs for children and families experiencing mental health emergency</i>	213
<i>SAFTY</i>	<i>A mobile crisis response program for children, youth and families; available 24/7</i>	737
Residential Services	Provide intensive 24-hour services for individuals who cannot be served in the community	108
<i>Inpatient Services</i>	<i>24-hour services for persons whose needs cannot be met in the community</i>	106
<i>Residential</i>	<i>Mental health services for children who have been temporarily placed in a facility</i>	2
Substance Use Programs	Provide services for youth with substance use problems	762
<i>Outpatient Drug Free</i>	<i>Assessment, individual and group counseling and other supportive services for individuals with substance use problems</i>	762
Early Intervention Services	Provide early intervention and prevention services for young children and their families	251
<i>HeadStart</i>	<i>Classrooms for children under 5 to promote school readiness for children from low-income backgrounds through education, health, social, and other services</i>	118
<i>PEI – Early Childhood</i>	<i>Prevention and early intervention services for children five or under</i>	125
<i>Prevention and Early Intervention (PEI) - TAY</i>	<i>Early screening and treatment services for individuals experiencing prodromal symptoms, the onset of a psychotic illness, or other serious mental illness; provide outreach and education to the community</i>	8
School-Based Services	Services for students that are provided in their schools	242
<i>School-Based Programs</i>	<i>Early identification of alcohol and other drug problems related to the use or abuse of drugs and services for mild-to-moderate mental illness</i>	223
<i>Healthy Start</i>	<i>School-community integrated services and activities, including medical care; mental health counseling; family support; academic support; psychoeducation; employment preparation; and others</i>	2
<i>AB3632</i>	<i>Mental health services provided for students with disabilities who are enrolled in special education</i>	17
In-Home Services	Provide services to children and their families in their home settings	481
<i>HOPE</i>	<i>Provide an array of intensive in-home services to foster home and extended family home placements to maintain the stability of children in their homes and placements</i>	318
<i>Intensive In-Home Care</i>	<i>A home-based model of service delivery, which includes stress management, communication and parenting skills, and behavioral interventions, to help families solve problems within the context of their home environment</i>	163

Wraparound Services	Team of providers develop individualized, comprehensive services	249
<i>SPIRIT</i>	<i>Wraparound program that provides a family-focused, strength-based, individualized service to help children and their families meet needs through community supports or the mental health system</i>	94
<i>SB 163 Wraparound</i>	<i>Return children and youth in group home care to their communities and help children at imminent risk of placement to remain in their homes</i>	53
<i>START (Support, Treatment, Advocacy and Referral Team)</i>	<i>Provide mental health assessment, screening and treatment, home visits, school collaborations, family interventions, linkage, and education for children, adolescents and families; school-based program offers prevention and early intervention mental health services to students in Carpinteria public schools experiencing emotional and/or behavioral difficulties.</i>	102
Behavioral Interventions	Interventions that use reinforcement and other behavioral principles	318
<i>Rehabilitation Specialists</i>	<i>Intensive and individualized behavioral interventions designed to help youth develop interpersonal and social skills, manage negative behaviors, and succeed in their home, school and community</i>	111
<i>Therapeutic Behavioral Services (TBS)</i>	<i>Short-term, strength-based, behavioral-focused service that works with children, caregivers, and the primary mental health provider to address behaviors that put a child at risk for a higher level of care</i>	207
Juvenile Justice Services	Services provided to youth involved in the juvenile justice system	92
<i>Juvenile Justice Mental Health Services</i>	<i>Serve youth in the Santa Barbara County Juvenile Probation institutions, including juvenile hall, the Los Prietos Boys Camp, and the Los Prietos Academy; staff members also conduct evaluations for the juvenile court and provide outpatient psychotherapy for Probation youth</i>	92
Outpatient Services	Services provided to individuals in the community	1667
<i>Child Wellness, Recovery, and Resiliency</i>	<i>Specialized outpatient teams that use evidence-based practices to serve children with serious emotional disturbance</i>	412
<i>Outpatient Services</i>	<i>Provide a variety of services to individuals in the community</i>	787
<i>Day Treatment</i>	<i>Intensive outpatient services for individuals that require a greater level of care, but not at a level requiring full-time services in a hospital</i>	2
<i>Managed Care</i>	<i>Provide children who are Medi-Cal beneficiaries and their families brief, time-limited therapy</i>	466
<i>New Heights – TAY</i>	<i>Assist transition-age youth in making a successful transition into adulthood by offering recovery-focused services, including mental health treatment, employment and education support and referrals, socialization support, and linkage to other service providers and community resources</i>	12
<i>Therapeutic Aide Program</i>	<i>Provide social and independent living skills training to children and youth for the purpose of establishing and maintaining positive social relationships with peers, family, and community members</i>	72
FFS	Fee-for-services programs	267
Intake and Assessment	Provide evaluations to determine potential diagnoses and treatment needs	2
Parent Partner	Persons with lived experience who provide support to parents of children being served in the mental health system and serve on treatment teams	38

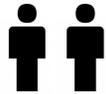
Participation in different types of programs was examined for racial and ethnic disproportionalities (see Table 15).

- **Crisis services** serve youth in a psychiatric crisis or mental health emergency. Latino/a youth were underrepresented whereas White, African American, and Other youth were overrepresented in these services.
- **Residential services** provide 24/7 services to youths whose needs are too great to be served in the county. Asian/Pacific Islander and Other youth were overrepresented in this population.
- **Wraparound services** provide comprehensive, individualized treatment as devised by a multidisciplinary team. Asian and Pacific Islander students were overrepresented in wraparound services' clients.
- **Substance use services** are provided to youth with alcohol or drug problems. Other and White youth were underrepresented for services in this category. Other students made up 1.5% of substance use services clients but 3.0% of the overall population of clients.
- **Juvenile justice services** are mental health and evaluation services provided to youth involved in the juvenile justice system either in custody or on probation. African American, Asian or Pacific Islander, and Other adolescents were more likely than White adolescents to be receiving services through the juvenile justice system.
- **School-based services** are services that are provided to youth and their families at their schools. White and Other youth were underrepresented in these services while African American and Latino youth were overrepresented. White youth composed 20.9% of the overall population of Behavioral Wellness clients but only 11.7% percent of clients in school-based programs.
- **In-home services** are mental health services and trainings that are provided to clients and their families in their own homes. African American and Other youth were overrepresented while Latino/a youth were underrepresented in these services. African American youth, who comprised 2.9% of the overall population, made up 5.6% of clients receiving in-home services. Similarly, Other youth, who made up only 3.0% of the overall population, composed 6.1% of in-home services recipients.
- **Early intervention** services are services that are provided to clients as preventative measures or at the very onset of symptoms. African American clients were underrepresented in Early Intervention services and Latino/a clients were overrepresented. African Americans made up only .9% of the population receiving early intervention services (and 2.9% of the overall population of clients). Latino/a clients comprised 84.5% of Early Intervention recipients (and 72.6% of the overall population).
- **FFS**, or fee-for-services programs, had overrepresentation of Latino/a and Other youth compared to White youth, who were underrepresented in these programs compared to their overall representation in the population.
- **Behavior intervention** programs use behavioral principles to guide treatment. They tend to be research-based programs. African American and Other youth were overrepresented in these programs whereas Latino/a and Asian/Pacific Islander youth were underrepresented.
- **Outpatient services** include a wide range of mental health services that are provided to children and adolescents in community settings. African American, Asian/Pacific Islander, and Other youth appeared to be somewhat overrepresented in these types of services.
- **Managed care** is short-term therapy that is provided to Medi-Cal clients and their families. White and African American youth were overrepresented in this program. White youth, who were about 20.9% of the overall Behavioral Wellness clients, comprised 29.4% of the Managed Care population.

Meanwhile, Latino/a youth made up 72.6% of the overall population and only 63% of Managed Care clients.

- **Child Wellness, Recovery, and Resilience** is a program that uses evidenced-based practices to provide outpatient services for children and adolescents with serious emotional disturbance. African American and Other youth were overrepresented in this program compared to their representation in the overall population of clients.

Table 15. Diagnoses for Department of Behavioral Wellness clients by race/ethnicity

	White	African American	Latino/a
Juvenile Justice Services	 1	 1.27	 1.10
School-Based Services	 1	 2.30	 2.03
In-Home Services	 1	 1.72	 .79
FFS	 1	 1.05	 1.82
Early Intervention Services	 1	 .48	 1.89

Behavior Intervention Services	 1	 1.58	 .83
Child Wellness, Recovery, and Resilience Program	 1	 1.77	 1.05

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁷⁸
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Crisis Services	182	30	462	4	30	708
<i>Crisis Services Percent</i>	25.7%	4.2%	65.3%	.6%	4.2%	100%
Rate Crisis Services (per 1,000 clients)	329.7	389.6	241.4	266.7	379.7	268.5
Disparity Gap – Crisis Services	1.00	1.18	.73	.81	1.15	.81
Residential Services	19	3	75	2	4	103
<i>Residential Percent</i>	18.4%	2.9%	72.8%	1.9%	3.9%	39.1%
Rate Residential (per 1,000 clients)	34.4	39.0	39.2	133.3	50.6	39.1
Disparity Gap – Residential	1.00	1.13	1.14	3.87	1.47	1.13
Wraparound Services	61	7	157	3	6	234
<i>Wraparound Percent</i>	26.1%	3.0%	67.1%	1.3%	2.6%	100%
Rate Wraparound (per 1,000 clients)	110.5	90.9	82.0	200	75.9	88.7
Disparity Gap – Wraparound	1.00	.82	.74	1.81	.69	.80
Substance Use Services	127	22	584	4	11	748
<i>Substance Use Percent</i>	16.9%	2.9%	78.1%	.5%	1.5%	100%
Rate Substance Use (per 1,000 clients)	230.1	285.7	305.1	266.7	139.2	283.7
Disparity Gap – Substance Use	1.00	1.24	1.33	1.16	.61	1.23
Juvenile Justice Services	17	3	65	1	5	91
<i>Juvenile Justice Percent</i>	18.7%	3.3%	71.4%	1.1%	5.5%	100%
Rate Juvenile Justice (per 1,000 clients)	30.8	39.0	34.0	66.7	63.3	34.5
Disparity Gap – Juvenile Justice	1.00	1.27	1.10	2.65	2.06	1.12
School-Based Services	28	9	197	1	4	239
<i>School-Based Services Percent</i>	11.7%	3.8%	82.4%	.4%	1.7%	100%
Rate School-Based Services	50.7	116.9	102.9	66.7	50.6	90.6

⁷⁸ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

(per 1,000 clients)						
Disparity Gap – School-Based Services	1.00	2.30	2.03	1.31	1.00	1.79
In-Home Services	104	25	285	3	27	444
<i>In-Home Services Percent</i>	<i>23.4%</i>	<i>5.6%</i>	<i>64.2%</i>	<i>6.8%</i>	<i>6.1%</i>	<i>100%</i>
Rate In-Home Services (per 1,000 clients)	188.4	324.7	148.9	200.0	341.8	168.4
Disparity Gap – In-Home Services	1.00	1.72	.79	1.06	1.81	.89
FFS	34	5	215	1	11	266
<i>FFS Percent</i>	<i>12.8%</i>	<i>1.9%</i>	<i>80.8%</i>	<i>.4%</i>	<i>4.1%</i>	<i>100%</i>
Rate FFS (per 1,000 clients)	61.6	64.9	112.3	66.7	139.2	100.9
Disparity Gap – FFS Services	1.00	1.05	1.82	1.08	2.26	1.64
Early Intervention Services	30	2	197	0	4	233
<i>Early Intervention Percent</i>	<i>12.9%</i>	<i>.9%</i>	<i>84.5%</i>	<i>0%</i>	<i>1.7%</i>	<i>100%</i>
Rate Early Intervention (per 1,000 clients)	54.3	26.0	102.9	0	50.6	88.3
Disparity Gap – Early Intervention	1.00	.48	1.89	0	.93	1.63
Behavior Intervention Services	59	13	170	1	14	257
<i>Behavior Intervention Percent</i>	<i>23.0%</i>	<i>5.1%</i>	<i>66.1%</i>	<i>.4%</i>	<i>5.4%</i>	<i>100%</i>
Rate Behavior Intervention (per 1,000 clients)	106.9	168.8	88.8	66.7	177.2	97.5
Disparity Gap – Behavior Intervention	1.00	1.58	.83	.62	1.66	.91
Outpatient Services	152	30	554	6	31	773
<i>Outpatient Services Percent</i>	<i>19.7%</i>	<i>3.9%</i>	<i>71.7%</i>	<i>.8%</i>	<i>4.1%</i>	<i>100%</i>
Rate Outpatient Services (per 1,000 clients)	275.4	389.6	289.4	400.0	392.4	293.1
Disparity Gap - Outpatient Services	1.00	1.41	1.05	1.45	1.42	1.06
Managed Care	132	19	283	3	12	449
<i>Managed Care Percent</i>	<i>29.4%</i>	<i>4.2%</i>	<i>63.0%</i>	<i>.7%</i>	<i>2.7%</i>	<i>100%</i>
Rate Managed Care (per 1,000 clients)	239.1	246.8	147.9	200.0	151.9	170.3
Disparity Gap – Managed Care	1.00	1.03	.62	.84	.64	.71
Child Wellness, Recovery, and Resilience Program	77	19	280	2	19	397
<i>Child Wellness Services Percent</i>	<i>19.4%</i>	<i>4.8%</i>	<i>70.5%</i>	<i>.5%</i>	<i>4.8%</i>	<i>100%</i>
Rate Child Wellness Services (per 1,000 clients)	139.5	246.8	146.3	133.3	240.5	150.5
Disparity Gap – Child Wellness	1.00	1.77	1.05	.96	1.72	1.08

Binary logistic regressions were used to determine whether these racial and ethnic disproportionalities in program participation remained after controlling for other background characteristics (i.e., gender, age, probation status, and diagnoses). Results are presented in Tables 16-19.

After controlling for other variables, race and ethnicity were no longer significant predictors of crisis services, residential services, or wraparound services. The odds of receiving crisis services were greater for older youth and youth with diagnoses of Psychotic Disorders, Mood Disorders, and Adjustment Disorders. The odds of receiving residential services were greater for youth with Psychotic Disorders or Mood Disorders. The

odds of receiving wraparound services were greater for youth with Mood Disorders, Anxiety Disorders, and Adjustment Disorders.

Table 16. Predictors of Receipt of Crisis, Residential Services, and Wraparound Services

	Crisis Odds Ratio (OR)	Residential Odds Ratio (OR)	Wraparound Services Odds Ratio (OR)
Gender (female)	1.02 (.38-2.73)	.28 (.04-2.01)	1.13 (.33-3.84)
Age	1.21 (1.08-1.35)**	1.09 (.85-1.40)	1.07 (.92-1.24)
African American	.47 (.01-16.79)	-	-
Asian/Pacific Islander	.73 (.23-2.34)	.38 (.04-3.33)	.48 (.12-1.89)
Latino/a	2.87 (.03-261.38)	2.78 (.08-95.46)	-
Primary language (not English)	1.16 (.39-3.44)	7.00 (.84-59.81)	.79 (.20-3.16)
Probation	1.62 (.05-50.65)	-	.90 (.04-20.34)
ADHD	1.90 (.44-8.25)	1.06 (.08-14.88)	1.19 (.20-7.26)
Disruptive Behavior Disorder	3.25 (.59-18.03)	12.18 (.36-411.20)	2.67 (.23-31.20)
Substance Use Disorder	.55 (.10-2.90)	.10 (.003-2.61)	2.04 (.35-11.97)
Psychosis	10.31 (3.06-34.78)***	64.33 (4.98-831.37)**	4.32 (.97-19.16)
Mood Disorder	5.72 (1.68-19.49)**	51.43 (5.23-505.57)**	4.37 (1.18-16.13)*
Anxiety Disorder	2.30 (.75-7.04)	1.60 (.21-12.05)	15.67 (3.25-75.58)**
Adjustment Disorder	3.31 (1.12-9.74)*	2.12 (.31-14.60)	4.21 (1.19-14.87)*

* $p < .05$. ** $p < .01$. *** $p < .001$.

After controlling for other variables, race and ethnicity were no longer significant predictors of receipt of school-based services, in-home services, or FFS. The odds of receiving school-based services were greater for students with ADHD, Anxiety Disorders, and Adjustment Disorders. The odds of receiving in-home services were greater for younger children and children with Psychotic Disorders, Anxiety Disorders, and Adjustment Disorders. The odds of receiving FFS were greater for children and adolescents with Adjustment Disorders and Substance Use Disorders.

Table 17. Predictors of Receipt of School-based Services, In-Home Services, and FFS

	School-Based Services Odds Ratio (OR)	In-Home Services Odds Ratio (OR)	FFS Odds Ratio (OR)
Gender (female)	2.15 (.52-8.84)	1.21 (.50-2.93)	.91 (.13-6.36)
Age	1.01 (.85-1.20)	.84 (.74-.97)*	1.04 (.83-1.31)
African American	6.09 (.41-91.33)	1.03 (.08-12.79)	-
Asian/Pacific Islander	1.10 (.20-5.97)	1.60 (.47-5.38)	3.23 (.19-54.01)
Latino/a	-	1.72 (.09-33.81)	7.24 (.16-327.85)
Primary language (not English)	.50 (.10-2.63)	.54 (.20-1.49)	.43 (.05-3.67)
Probation	-	-	-
ADHD	7.34 (1.24-43.31)*	3.11 (.75-12.88)	6.48 (.82-51.03)
Disruptive Behavior Disorder	.97 (.05-19.32)	3.19 (.68-14.89)	3.06 (.12-78.52)
Substance Use Disorder	2.27 (.16-31.98)	1.41 (.18-10.76)	14.22 (1.03-197.05)*
Psychosis	.10 (.01-1.22)	4.52 (1.31-15.58)*	1.02 (.09-11.52)
Mood Disorder	3.18 (.55-18.41)	2.87 (.76-10.91)	1.82 (.22-14.77)
Anxiety Disorder	8.83 (1.53-50.83)*	5.67 (1.85-17.39)**	1.58 (.17-15.00)
Adjustment Disorder	5.11 (1.36-19.23)*	13.44 (5.42-33.34)***	13.47 (1.78-101.80)*

* $p < .05$. ** $p < .01$. *** $p < .001$.

After controlling for other variables, race and ethnicity were no longer predictors of receipt of behavior interventions or early interventions. The odds of receiving behavior interventions were greater for youth with ADHD, Disruptive Behavior Disorders, Psychotic Disorders, and Adjustment Disorders. The odds of receiving early interventions were greater for younger children and children whose primary language was not English. The odds of participating in early intervention services were 2.92 times greater for youth whose primary language was not English. On the other hand, the odds of receiving early intervention services were lower for youth with Psychotic Disorders and Anxiety Disorders.

Table 18. Predictors of Participation in Behavior Interventions, Early Interventions, and Managed Care

	Behavior Intervention Odds Ratio (OR)	Early Intervention Odds Ratio (OR)
Gender (female)	.41 (.11-1.48)	1.39 (.57-3.36)
Age	1.10 (.95-1.28)	.76 (.67-.86)***
African American	4.95 (.19-125.86)	.12 (.01-1.40)
Asian/Pacific Islander	4.87 (.76-31.34)	1.75 (.55-5.58)
Latino/a	-	.26 (.02-4.38)
Primary language (not English)	1.54 (.43-5.52)	2.92 (1.08-7.95)*
Probation	1.86 (.03-130.53)	-
ADHD	66.62 (11.52-385.23)***	.50 (.09-2.96)
Disruptive Behavior Disorder	15.52 (2.23-107.84)**	.55 (.12-2.54)
Substance Use Disorder	.27 (.02-3.20)	4.82 (.60-38.74)
Psychosis	5.41 (1.33-22.02)*	.07 (.01-.38)**
Mood Disorder	2.94 (.78-11.04)	3.41 (.68-17.04)
Anxiety Disorder	3.21 (.82-12.46)	.23 (.08-.68)**
Adjustment Disorder	4.04 (1.11-14.67)*	1.82 (.65-5.11)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Lastly, after controlling for other variables, race and ethnicity were no longer significant predictors of participation in Child Wellness, Recovery, and Resilience or Managed Care. Males were more likely to participate in Managed Care as were children with Anxiety Disorders. The odds of participating in Child Wellness, Recovery, and Resilience were greater for youth with Psychotic Disorders. Finally, younger children, African American youth, and youth with Mood Disorders, Anxiety Disorders, or Adjustment Disorders were more likely to participate in Outpatient Services. The odds of participating in Outpatient Services were 8.36 times higher for African American youth compared to White youth.

Table 19. Predictors of Participation in Therapeutic Aide Program; Child Wellness, Recovery, and Resilience; and Outpatient Services

	Child Wellness, Recovery, and Resilience Odds Ratio (OR)	Outpatient Services Odds Ratio (OR)	Managed Care Odds Ratio (OR)
Gender (female)	.45 (.16-1.29)	1.38 (.71-2.70)	.36 (.14-.95)*
Age	1.08 (.95-1.22)	.90 (.81-1.00)*	1.11 (1.00-1.24)
African American	6.68 (.57-78.26)	8.36 (1.29-54.02)*	-
Asian/Pacific Islander	2.64 (.69-10.13)	1.67 (.67-4.17)	.65 (.23-1.88)
Latino/a	-	.37 (.03-5.73)	.36 (.02-6.85)
Primary language (not English)	.67 (.22-2.00)	.50 (.24-1.06)	.49 (.17-1.42)
Probation	-	3.48 (.12-98.42)	3.89 (.14-108.40)
ADHD	3.82 (.90-16.28)	-	1.06 (.25-4.55)
Disruptive Behavior Disorder	4.65 (.91-23.79)	2.66 (.72-9.85)	4.85 (.99-23.78)
Substance Use Disorder	2.25 (.48-10.58)	.72 (.14-3.77)	.10 (.01-1.04)
Psychosis	6.90 (1.98-24.05)**	2.05 (.68-6.21)	1.85 (.57-5.96)
Mood Disorder	1.08 (.35-3.32)	3.99 (1.29-12.40)*	2.64 (.86-8.14)
Anxiety Disorder	2.26 (.74-6.92)	2.50 (1.02-6.13)*	6.72 (2.27-19.94)**
Adjustment Disorder	1.85 (.62-5.53)	3.00 (1.37-6.60)**	1.47 (.53-4.07)

* $p < .05$. ** $p < .01$. *** $p < .001$.

There was a large amount of variability in the amount of time and the number of services children received as clients of the Department of Behavioral Wellness. On average, youth remained clients of the Department of Behavioral Wellness for about 1.31 years; the minimum length of time spent as a client was 1 day and the maximum was 16 years. During this time, youth received anywhere from 0 services to 2,477 services with an average of 79.2 services received.

A number of factors predicted the amount of time youth spent as clients and the number of services they received (see Table 20). Linear regression analyses revealed two significant predictors of the amount of time youth remained clients of the Department of Behavioral Wellness: age and number of diagnoses. Children who had their initial admissions into the system at younger ages and children with a larger number of diagnoses spent more time as clients. Race and ethnicity did not predict how long children remained clients after controlling for other background characteristics.

Linear regression analysis revealed five significant predictors of the total number of services children received. First, youth classified as Other for race or ethnicity received fewer services. Additionally, children and youth with a greater number of diagnoses received more services. Finally, a diagnosis of ADHD predicted greater number of services whereas diagnoses of Adjustment Disorders and Substance Use Disorders predicted fewer services.

Table 20. Predictors of Service Receipt

	Length of Time B (95% CI)	Number of Services B (95% CI)
Gender (female)	.10 (-.32 - .52)	2.35 (-71.02 - 75.73)
Age	-.12 (-.18 - -.07)***	-8.31 (-18.12 - 1.51)
African American	-.71 (-1.85 - .44)	-12.83 (-213.19 - 187.53)
Latino/a	-.13 (-.67 - .42)	38.98 (-55.92 - 133.87)
Other	-1.30 (-2.75 - .14)	-288.10 (-549.76 - -35.44)*
Primary language (not English)	-.47 (-.95 - .01)	24.50 (-59.37 - 108.37)
Number of Disorders	.93 (.54-1.32)***	153.36 (85.42 - 221.29)***
ADHD	.75 (-.27 - 1.77)	284.83 (106.42 - 463.23)**
Disruptive Behavior Disorder	.74 (-.17 - 1.65)	-107.56 (-267.22 - 52.10)
Substance Use Disorder	-.97 (-2.03 - .09)	-277.23 (-462.59 - 91.87)**
Psychotic Disorder	-.12 (-.90 - .65)	-24.55 (-160.38 - 111.29)
Mood Disorder	-.20 (-1.13 - .74)	-62.46 (-225.99 - 101.07)
Anxiety Disorder	.66 (-.06 - 1.37)	-52.16 (-177.66 - 73.33)
Adjustment Disorder	.48 (-.19 - 1.15)	-138.79 (-256.38 - -21.21)*

* $p < .05$. ** $p < .01$. *** $p < .001$.

Outcomes

Finally, data were examined to determine if there were disproportionalities in outcomes for clients of color. In general, there were three main reasons for clients being discharged: they had satisfactory progress and completed the program or were released early; they had unsatisfactory progress, no progress, or were noncompliant with treatment or fees; or they were incarcerated. For some clients, a reason for discharge was not given or was unrelated to treatment outcomes (e.g., the client moved).

Compared to White youth, African American and Asian or Pacific Islander youth were more likely to be discharged from treatment with satisfactory progress. White youth were the least likely to be released with unsatisfactory progress: compared to White youth African American, Latino/a, Asian or Pacific Islander, and Other youth were all more likely to be released with unsatisfactory progress or treatment noncompliance. African American and Latino/a youth were also significantly more likely to be discharged due to incarceration. For every two White youth who were discharged due to incarceration, three Latino/a and four African American youth were discharged due to incarceration. African American and Other youth were also more likely to be discharged for other reasons unrelated to treatment progress.

Table 21. Reason for Discharge by Race/Ethnicity

	White	African American	Latino/a
Incarceration	 1	 2.15	 1.50

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁷⁹
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Satisfactory Progress	42	9	151	2	7	211
<i>Satisfactory Progress Percent</i>	19.9%	4.3%	71.6%	.9%	3.3%	100%
Rate Satisfactory Progress (per 1,000 clients)	76.1	116.9	78.9	133.3	88.6	80.0
Disparity Gap – Satisfactory Progress	1.00	1.54	1.04	1.75	1.16	1.05
Unsatisfactory Progress/ Noncompliance	286	48	1205	11	49	1599
<i>Unsatisfactory Progress Percent</i>	17.9%	3.0%	75.4%	.7%	3.1%	100%
Rate Unsatisfactory Progress (per 1,000 clients)	518.1	623.4	629.6	733.3	620.2	606.4
Disparity Gap – Unsatisfactory Progress	1.00	1.20	1.22	1.42	1.20	1.17
Incarceration	10	3	52	0	1	66
<i>Incarceration Percent</i>	15.2%	4.5%	78.8%	0%	1.5%	100%
Rate Incarceration (per 1,000 clients)	18.1	39.0	27.2	0	12.7	25.0
Disparity Gap – Incarceration	1.00	2.15	1.50	0	.70	1.38
Other (i.e., moved, transferred, etc.)	120	27	469	4	25	645
<i>Other Percent</i>	18.6%	4.2%	72.7%	.6%	3.9%	100%
Rate Other (per 1,000 clients)	217.4	350.6	245.0	266.7	316.5	244.6
Disparity Gap – Other	1.00	1.61	1.13	1.23	1.46	1.13

These disparities disappear when other background characteristics are taken into account. After controlling for other background variables, including gender, race or ethnicity, age, primary language, probation status and diagnosis, only diagnosis was a significant predictor of discharge due to satisfactory progress. Children and adolescents with Mood Disorders and Anxiety Disorders had greater odds of being released for satisfactory progress. Age was a significant predictor of unsatisfactory progress with younger children being more likely to be released for unsatisfactory progress or noncompliance. Additionally, youth with Substance Use Disorders and Adjustment Disorders also had greater odds for being released with unsatisfactory progress or noncompliance. The odds for being released due to noncompliance or unsatisfactory progress was over 17 times greater for youths diagnosed with Substance Use Disorders. Finally the only predictors of having an “other” discharge were a diagnosis of ADHD or Adjustment Disorder.

⁷⁹ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

Table 22. Predictors of Reason for Discharge

	Satisfactory Progress B (95% CI)	Unsatisfactory Progress B (95% CI)	Other B (95% CI)
Gender (female)	1.68 (.55-5.11)	1.01 (.51-2.00)	.73 (.38-1.39)
Age	.90 (.78-1.05)	.90 (.82-1.00)*	.92 (.84-1.01)
African American	-	.39 (.05-2.91)	2.12 (.43-10.42)
Latino/a	1.87 (.38-9.15)	2.16 (.87-5.39)	.79 (.34-1.87)
Other	2.86 (.19-42.56)	.89 (.08-10.01)	.67 (.07-6.00)
Primary language (not English)	1.06 (.34-3.30)	1.65 (.77-3.54)	.88 (.43-1.83)
Probation		-	.41 (.02-7.96)
ADHD	1.60 (.32-8.00)	8.68 (.89-84.68)	5.68 (1.55-20.77)**
Disruptive Behavior Disorder	1.90 (.31-11.69)	2.03 (.46-8.91)	1.41 (.38-5.19)
Substance Use Disorder	3.07 (.40-23.42)	17.46 (1.75-174.72)*	2.30 (.52-10.22)
Psychotic Disorder	1.07 (.25-4.58)	1.10 (.34-3.54)	1.47 (.53-4.08)
Mood Disorder	4.51 (1.08-18.89)*	2.58 (.76-8.77)	1.84 (.65-5.20)
Anxiety Disorder	5.37 (1.48-19.57)*	.75 (.30-1.86)	1.14 (.49-2.63)
Adjustment Disorder	1.85 (.60-5.74)	15.96 (4.23-60.27)***	2.50 (1.20-5.23)*

* $p < .05$. ** $p < .01$. *** $p < .001$.

Most clients are sent home to their families after they are discharged; however, some clients are transferred to more intensive treatment services, such as residential placements, and some clients are transferred to jail. Overall, twelve clients were transferred to jail upon discharge, the majority of which were Latino ($n = 10$; 83.3%). In addition, 74 clients were transferred to more intensive services. African American and other youth were most likely to be transferred to more intensive services. African American children made up 10.8% of all transfers to more intensive treatment services but composed only 2.9% of the overall youth clientele served by the Department of Behavioral Wellness.

Additionally, some clients leave treatment early without planning it with their treatment providers. In total, there were 20 unplanned discharges. African American youth were also more likely to have unplanned discharges than youth from other racial and ethnic backgrounds. In total, 10% of all unplanned discharges were for African American youth. See Table 23 for more details.

Table 23. Discharge Status by Race/Ethnicity

	White	African American	Latino/a
Transfer to Intensive Services	 1	 3.37	 .76
Transfer to Jail	 1	0	 2.88
Unplanned Discharge	 1	 3.58	 .94

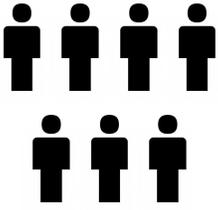
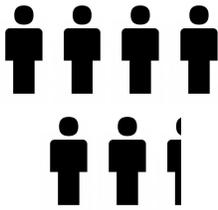
Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁸⁰
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Transfer to More Intensive Services	17	8	45	0	4	74
<i>Transfer Percent</i>	23.0%	10.8%	60.8%	0%	5.4%	100%
Rate Transfer (per 1,000 clients)	30.8	103.9	23.5	0	50.6	28.1
Disparity Gap – Transfer	1.00	3.37	.76	0	1.64	.91
Transfer to Jail	1	0	10	0	1	12
<i>Transfer to Jail Percent</i>	8.3%	0%	83.3%	0%	8.3%	100%
Rate Transfer to Jail (per 1,000 clients)	1.80	0	5.2	0	12.7	4.6
Disparity Gap – Transfer to Jail	1.00	0	2.88	0	6.99	2.51
Unplanned Discharge	4	2	13	0	1	20
<i>Unplanned Discharge Percent</i>	20.0%	10.0%	65.0%	0%	5.0%	100%
Rate Unplanned Discharge (per 1,000 clients)	7.2	26.0	6.8	0	12.7	7.6
Disparity Gap – Unplanned Discharge	1.00	3.58	.94	0	1.75	1.05

When clients are discharged, they are sometimes referred out to other programs so they can continue receiving services. About 29% of clients were referred to other types of treatment. African American and

⁸⁰ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

Other youth were somewhat more likely to be referred out to other treatment agencies. Some youth are referred to the criminal justice system at discharge. In total, 24 youth were referred to the criminal justice system. The vast majority of adolescents referred to the criminal justice system were Latino/a ($n = 22$; 91.7%). White youth were underrepresented in referrals to the criminal justice system. While White youth made up 20.9% of the overall population, they composed only 4.2% of referrals to the criminal justice system. Finally, some youth do not receive a referral at discharge. Latino/a and Asian/Pacific Islander youth were disproportionately likely to not be referred to additional treatment. See Table 24 for more information.

Table 24. Referral Out by Race/Ethnicity

	White	African American	Latino/a
Referral to Criminal Justice System	 1	 7.17	 6.34
No Referral	 1	 1.22	 1.59

Behavior Wellness Clients	White	African American	Latino/a	Asian/Pacific Islander	Other	Total
Total Clients Under 18	552	77	1914	15	79	2637⁸¹
<i>Admissions Percent</i>	20.9%	2.9%	72.6%	.6%	3.0%	100%
Other Treatment	162	28	525	4	34	753
<i>Other Treatment Percent</i>	21.5%	3.7%	69.7%	.5%	4.5%	100%
Rate Satisfactory Progress (per 1,000 clients)	293.5	363.6	274.3	266.7	430.4	285.6
Disparity Gap – Other Treatment	1.00	1.24	.93	.91	1.47	.97
Criminal Justice	1	1	22	0	0	24
<i>Criminal Justice Percent</i>	4.2%	4.2%	91.7%	0%	0%	100%
Rate Unsatisfactory Progress (per 1,000 clients)	1.8	13.0	11.5	0	0	9.1
Disparity Gap – Criminal Justice	1.00	7.17	6.34	0	0	5.02
No Referral	59	10	326	3	8	406
<i>No Referral Percent</i>	14.5%	2.5%	80.3%	.7%	2.0%	100%
Rate No Referral (per 1,000 clients)	106.9	129.9	170.3	200.0	101.3	154.0
Disparity Gap – No Referral	1.00	1.22	1.59	1.87	.95	1.44

⁸¹ These numbers only include individuals for whom race/ethnicity was available. This information was missing for 152 individuals.

Binary logistic regression analyses were conducted to determine whether racial and ethnic disproportionalities remained after controlling for other background variables. Analyses could not be conducted on criminal justice referrals as there were not enough youth who had been referred to the criminal justice system. Racial and ethnic disproportionalities in treatment referrals and no referrals disappeared after controlling for other background variables. Youth with ADHD, Disruptive Behavior Disorder, Psychotic Disorder, Anxiety Disorders, and Adjustment Disorders had greater odds of being referred to other treatment. Youth with Substance Use Disorders had much higher odds of receiving no referral.

Table 25. Predictors of Referrals

	Other Treatment Referral B (95% CI)	No Referral B (95% CI)
Gender (female)	.86 (.38-1.97)	1.04 (.25-4.36)
Age	.90 (.80-1.02)	.96 (.80-1.16)
African American	.39 (.03-5.25)	-
Latino/a	.70 (.24-2.03)	3.45 (.31-38.94)
Other	.12 (.01-2.92)	-
Primary language (not English)	1.12 (.43-2.88)	2.18 (.47-10.16)
Probation	.26 (.01-6.80)	.11 (.00-5.96)
ADHD	6.06 (1.49-24.68)*	4.37 (.62-31.08)
Disruptive Behavior Disorder	18.92 (4.33-82.69)***	1.19 (.08-18.09)
Substance Use Disorder	4.05 (.73-22.52)	87.55 (7.87-974.53)***
Psychotic Disorder	5.32 (1.63-17.31)**	.46 (.06-3.85)
Mood Disorder	2.48 (.77-7.97)	4.46 (.76-26.02)
Anxiety Disorder	10.50 (3.64-30.28)***	1.95 (.36-10.65)
Adjustment Disorder	8.92 (3.49-22.81)***	3.24 (.67-15.75)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Summary of Findings

Client Demographics

- In total, the Department of Behavioral Wellness served 2,789 children and adolescents who were discharged between July 2009 and June 2014.
- Compared to the overall youth population in Santa Barbara County, White and Asian/Pacific Islander were underrepresented as Behavioral Wellness clients whereas African American and Latino/a youth were overrepresented.
- About 23% of clients spoke Spanish as their primary language.
- Approximately 95% of clients were listed as having no insurance at some point while they were receiving services through the Department of Behavioral Wellness.
- The average age of clients at first admission to the Department of Behavioral Wellness was approximately 9.9 years. Clients' ages at first admission ranged from less than 1 year to over 17 years.
- 113 youth were on probation at some point while they were receiving services.
 - White youth composed 20.9% of Behavioral Wellness clients but 11.6% of the youth who were concurrently on probation.
 - Latino youth were overrepresented among youth on probation.

Referrals

- Clients were referred to Behavioral Wellness by treatment agencies, the criminal justice system, medical health care providers, crisis services, CWS, community agencies, and schools.
- The largest number of youths was referred by schools or educational programs (n = 789) followed by individual referrals (n = 545) and treatment agencies (n = 499).
 - African American youth were overrepresented in referrals from treatment agencies, the criminal justice system, individuals, medical providers, community agencies, and CWS.
 - While African American children and adolescents only made up 2.9% of the overall clients served by the Department of Behavioral Wellness, they comprised 7.4% of the population referred by CWS.
 - Latino/a youth were overrepresented in referrals from schools and underrepresented in referrals from medical providers and CWS.
 - Latino/a children and adolescents composed 72.6% of the Behavioral Wellness clients and only 60.7% of clients referred by CWS.

Diagnoses

- Children and adolescents received services through Behavioral Wellness for a wide range of mental health problems, including Disorders of Infancy, Childhood, or Adolescence; Substance Use Disorders; Schizophrenia and other Psychotic Disorders; Mood Disorders; Anxiety Disorders; Factitious Disorders; Paraphilia or Sexual Disorders; Eating Disorders; Insomnia; Impulse Control Disorders; Adjustment Disorders; Relational Problems; Child Abuse; and Phase of Life problems.
 - Latino/a youth and children whose primary language was not English were underrepresented in ADHD diagnoses.
 - African American, Latino/a, and Other youth were more likely than White youth to have diagnoses for Disruptive Behavior Disorders, including Conduct Disorder and Oppositional Defiant Disorder.
 - These associations were not statistically significant when controlling for other variables.
 - Compared to White youth, Latino/a and Asian/Pacific Islander youth were more likely to have diagnoses for Substance Use Disorders whereas Other youth were underrepresented in this category.
 - African American clients were 2.7 times more likely and Latino/a youth were 2.25 times more likely than White youth to have diagnoses for Substance Use Disorders.

- Children and adolescents with a primary language other than English were less likely to have diagnoses for Substance Use Disorders.
- The odds of having a diagnosis of Substance Use Disorder were 97 times higher for youth on probation than youth not on probation
- Latino/a youth were underrepresented and Other youth were overrepresented in Mood Disorders relative to their White peers.
- Latino/a youth were less likely to have diagnoses for Anxiety Disorders than White youth.

Treatment

- Among Behavioral Wellness clients, Latino/a and African American clients were disproportionately likely to be enrolled in ADP programs whereas youth of Other race/ethnicity were underrepresented. This was commensurate with the rate of Substance Use Disorders in the population.
- The odds of having a being served by county agencies were 8 times higher for youth whose primary language was not English
- Specific Types of Programs:
 - Crisis services - Latino/a youth were underrepresented whereas White, African American, and Other youth were overrepresented.
 - Residential services – Asian or Pacific Islander and Other youth were overrepresented.
 - Wraparound services - Asian or Pacific Islander youth were overrepresented.
 - Substance use services - Other and White youth were underrepresented
 - Juvenile justice services - African American, Asian/Pacific Islander, and Other adolescents were overrepresented
 - School-based services -White and Other youth were underrepresented whereas African American and Latino youth were overrepresented
 - In-home services - African American and Other youth were overrepresented whereas Latino/a youth were underrepresented
 - Early intervention services - African American clients were underrepresented and Latino/a clients were overrepresented.
 - FFS - overrepresentation of Latino/a and Other youth compared to White youth, who were underrepresented
 - Behavior interventions - African American and Other youth were overrepresented whereas Latino/a and Asian or Pacific Islander youth were underrepresented.
 - Outpatient services - African American, Asian or Pacific Islander, and Other youth were overrepresented
- Almost all racial/ethnic disparities in specific programs were accounted for by other background variables and diagnoses.
 - The only association between race or ethnicity and service type that remained statistically significant was that African American youth were overrepresented in outpatient services. The odds of participating in outpatient services were 8.36 times higher for African American youth compared to White youth.
- Race and ethnicity did not predict how long children remained clients after controlling for other background characteristics
- Youth classified as Other for race or ethnicity received fewer services even after controlling for background characteristics and number and type of disorders.

Outcomes

- Compared to White youth, African American and Asian or Pacific Islander youth were more likely to be discharged from treatment with satisfactory progress.
- White youth were less likely to be released with unsatisfactory progress or treatment noncompliance than all other racial/ethnic groups.
- African American and Latino/a youth were also significantly more likely to be discharged due to incarceration.

- For every two White youth who were discharged due to incarceration, three Latino/a and four African American youth were discharged due to incarceration.
- Overall, twelve clients were transferred to jail upon discharge, the majority of whom were Latino ($n = 10$; 83.3%). For every one White youth transferred to jail upon discharge, seven African American and six Latino youth were transferred to jail.
- African American and other youth were most likely to be transferred to more intensive services. African American children made up 10.8% of all transfers to more intensive treatment services but only 2.9% of the overall clientele served by the Department of Behavioral Wellness.
- African American youth were also more likely to have unplanned discharges than youth from other racial and ethnic backgrounds. In total, 10% of all unplanned discharges were for African American youth.
- The vast majority of adolescents referred to the criminal justice system at discharge were Latino/a ($n = 22$; 91.7%). White youth were underrepresented in referrals to the criminal justice system. Although White youth made up 20.9% of the overall population, they were only 4.2% of referrals to the criminal justice system.
- Most disproportionalities in outcomes no longer emerged when controlling for other background variables and diagnoses.

Implications and Future Directions

Overall, a complicated picture emerges when examining racial and ethnic disproportionalities for clients being served by the Department of Behavioral Wellness. Simple correlations reveal a number of racial and ethnic disproportionalities throughout each stage of the system from admissions and referrals to diagnoses and treatment to outcomes. However, many of these disproportionalities disappear when other background variables are taken into account, suggesting that the situation is complex and may be compounded by disproportionalities at different points in the system. For the most part, treatment and outcome variables were explained by clients' diagnoses rather than race or ethnicity; however, racial and ethnic disproportionalities in diagnoses could obscure racial and ethnic disparities in treatment and outcomes. For example, Latino/a and African American youth are more likely to have diagnoses for Substance Use Disorders than White youth. Youth with Substance Use Disorders receive fewer services and are less likely to be referred for additional treatment, yet they are also over 17 times more likely to be discharged with unsatisfactory progress.

Compared to the overall youth population in Santa Barbara County, African American and Latino/a youth were overrepresented among Behavioral Wellness clients whereas Asian youth were underrepresented. African American and Latino/a youth appeared to have different entry points into the system. African American children and adolescents were overrepresented in referrals to Behavioral Wellness by CWS and the criminal justice system. Latino/a youth were overrepresented among referrals by schools and educational programs. These racial and ethnic differences in referrals indicate that many of the observed racial and ethnic disproportionalities within the mental health system may be inherited by from the other systems that feed into the mental health system. Any attempts to address racial and ethnic disproportionalities within the Department of Behavioral Wellness should also involve community agencies that refer clients for services. Similar patterns of diagnoses emerged for African American and Latino/a youth. Both African American and Latino/a youth were overrepresented in diagnoses for Disruptive Behavior Disorders and Substance Use Disorders compared to White youth. At the same time, Latino/a youth were underrepresented in diagnoses for ADHD. It is possible that given the same symptoms, White youth are more likely to receive diagnoses for ADHD whereas Latino/a youth are more likely to receive diagnoses of Disruptive Behavior Disorders.

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As far as treatment was concerned, a number of racial and ethnic disparity patterns were observed; however, it was difficult to ascertain whether different treatment programs were associated with different quality of treatment. Without a better understanding of which programs use evidence-based practices or provide more extensive services, it is difficult to say whether clients of color receive inferior treatment compared to White clients. Compared to White youth, both Latino/a and African American youths were more likely to receive school-based services. On the other hand opposite patterns emerged for in-home services and early intervention services: Latino/a children were overrepresented in early intervention services but underrepresented in in-home services whereas African American children were overrepresented in in-home services and underrepresented in early intervention services. Both of these types of treatment could be critical in promoting positive outcomes for children and adolescents with mental health concerns. Early intervention services serve a preventative function; their goal is to prevent serious emotional and behavioral problems from emerging. In-home services may help increase access to mental health services by removing transportation and time barriers. These disproportionalities in treatment services may also be related to where clients are receiving services. The racial and ethnic composition of residents in Santa Barbara County varies by location. For example, 61% of the population in North County are Latino/a whereas only 32% of the

population in South county are Latino/a.⁸² There are differences in which programs are provided in different parts of the county, so racial and ethnic differences in treatment participation may be reflecting the differences in service availability in different parts of the county.

Racial and ethnic disproportionalities in outcomes were also observed, with African American clients generally having the most negative outcomes. African American clients were overrepresented in transfers to more intensive treatment services, suggesting that they were more likely to have symptoms that did not abate or got worse during treatment. They also had higher odds of having unplanned discharges, which may indicate that they are more likely to drop out of treatment without completing it. Some clients of color drop out of treatment early when treatment is not aligned with their cultural values and beliefs or when they cannot identify with their clinicians culturally, racially, or ethnically.

The most striking pattern of disproportionalities that emerged in the report was the overrepresentation of African American and Latino/a clients in concurrent juvenile justice and mental health involvement. The odds of being on probation while receiving services from Behavioral Wellness were 1.65 times higher for African American than White youth and twice as high for Latino/a youth compared to White youth. African American youth were also more likely than White youth to have been referred for treatment by the criminal justice

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system and were more likely to be receiving mental health services through the juvenile justice system. Most importantly, African American and Latino/a youth were more likely to be discharged due to incarceration or transferred to jail upon discharge: the odds of being discharged due to incarceration were 2.15 times higher for African American youth than they were for White youth, and the odds of being transferred to jail upon discharge was 2.88 times higher for Latino/a youth than for White youth. At discharge, for every one White youth who was referred to the criminal justice system, seven African American and six Latino/a youth were referred to the criminal justice system. Thus, it is clear that racial and ethnic disproportionalities occur within the mental health and

alcohol and drug system and play a role in the racial and ethnic disproportionalities observed in the juvenile justice system.

Future Directions

Based on results from the current evaluation, a number of future directions are proposed to better understand and address racial and ethnic disproportionalities within the mental health system.

1. Develop systematic protocols for tracking client information.

The systematic analysis of data is key to identifying and addressing racial and ethnic disproportionalities; however, these analyses are only as useful as the data are accurate and complete. As efforts to address disparities in mental health service use in Santa Barbara County are being implemented, it will be essential that steps are taken to ensure that the data collected by the Santa Barbara Behavioral Wellness Department and the agencies it contracts with are precise and correct. Systematic protocols for collecting and entering data can be useful in guaranteeing that data are consistently collected across different agencies and different individuals.

In addition, it may be helpful to consider collecting additional data. For example, fidelity data can be useful in measuring the extent to which evidence-based programs are being implemented as intended. These types of data would help address whether the quality of programs differs for clients of different racial and ethnic groups. In addition, pre- and post- tests measurements may also be

⁸² U.S. Census 2010 Decennial Count

useful in conducting more in-depth investigations into clients' outcomes and the effectiveness of different types of treatment programs for clients of color.

2. Hire and contract with more mental health providers who are bilingual and have been trained to work with clients of color.

Unfortunately, there is a shortage of mental health providers who are well qualified to work with clients of color and clients who do not speak English as their primary language. Attempts should be made to hire clinicians who are bilingual and are trained to work with culturally diverse populations. Without proper training, it is possible that mental health professionals can do more harm than good when working with clients of color. Research indicates that culturally adapted interventions are more effective than traditional interventions.⁸³ Many traditional therapies endorse individualistic values that may not be a good match from clients who come from different cultural backgrounds.⁸⁴ In addition, many studies show that clients of color, particularly African American clients, prefer working with therapists who belong to their same racial or ethnic group and who speak the same language as them.⁸⁵

3. Provide multicultural and implicit bias trainings for staff members and for community members who frequently refer to the Department of Behavioral Wellness.

Additional steps should be taken to provide multicultural and implicit bias trainings for staff members who work for the Department of Behavioral Wellness as well as for individuals from the community who work at agencies that frequently refer clients to Behavioral Wellness. Multicultural trainings can help individuals develop an enhanced awareness of their own cultural and racial experiences, attitudes, and biases; knowledge of other worldviews and systematic factors that influence others; and skills to deliver culturally competent services.⁸⁶ Implicit bias trainings are intended to address biases that are not explicit and that individuals may not be aware that they hold.⁸⁷ Given that racial and ethnic disproportionalities begin even before individuals' first contact with the Department of Behavioral Wellness, expanding these trainings to include community members who refer children and adolescents for mental health services as well as mental health professionals who provide treatment may be useful in addressing racial and ethnic disparities that occur at all levels of the system.

4. Conduct in-depth, qualitative investigations with staff members, clients, and community members to develop a more nuanced understanding of the exact nature of racial and ethnic disproportionalities.

Results from the current evaluation provided preliminary evidence for racial and ethnic disproportionalities within the mental health system in Santa Barbara County. However, pre-existing data is limited in how much insight it can provide. In order to develop a more comprehensive understanding of the problems facing clients of color, a more in-depth investigation is necessary. In particular, it is important to talk to the clients themselves to understand their experiences within the

⁸³ La Roche, M., Christopher, M. S., & West, L. M. (2017). Toward a cultural evidence-based psychotherapy. In Casas, J. M., Suzuki, L. A., Alexander, C. M., & Jackson, M. A. (Eds.), *Handbook of multicultural counseling (4th ed.)*. Thousand Oaks, CA: SAGE Publications.

⁸⁴ La Roche, M., Christopher, M. S., & West, L. M. (2017). Toward a cultural evidence-based psychotherapy. In Casas, J. M., Suzuki, L. A., Alexander, C. M., & Jackson, M. A. (Eds.), *Handbook of multicultural counseling (4th ed.)*. Thousand Oaks, CA: SAGE Publications.

⁸⁵ La Roche, M., Christopher, M. S., & West, L. M. (2017). Toward a cultural evidence-based psychotherapy. In Casas, J. M., Suzuki, L. A., Alexander, C. M., & Jackson, M. A. (Eds.), *Handbook of multicultural counseling (4th ed.)*. Thousand Oaks, CA: SAGE Publications.

⁸⁶ Duan, C., & Smith, A. (2017). Multicultural training and supervision in research and service. In Casas, J. M., Suzuki, L. A., Alexander, C. M., & Jackson, M. A. (Eds.), *Handbook of multicultural counseling (4th ed.)*. Thousand Oaks, CA: SAGE Publications.

⁸⁷ Jackson, S. M., Hillard, A. L., & Sneider, T. R. (2014). Using implicit bias training to improve attitudes toward women in STEM. *Social Psychology of Education, 17*, 419-438. doi: 10.1007/s11218-014-9259-5

mental health system. In the next year, interviews or focus groups should be conducted with mental health therapists, clients of the Department of Behavioral Wellness, individuals who work for the primary referring agencies, and members of the community to better understand the underlying causes of racial and ethnic disproportionalities in mental health. Mental health professionals and individuals from referring agencies can provide insight on the nature of the treatments that are provided, the training and qualifications of mental health service providers, how referrals are made to and from the Department of Behavioral Wellness, and how decisions are made regarding who receives what treatment. Clients and community members can share their experiences of the system and the barriers they face in accessing appropriate treatment.